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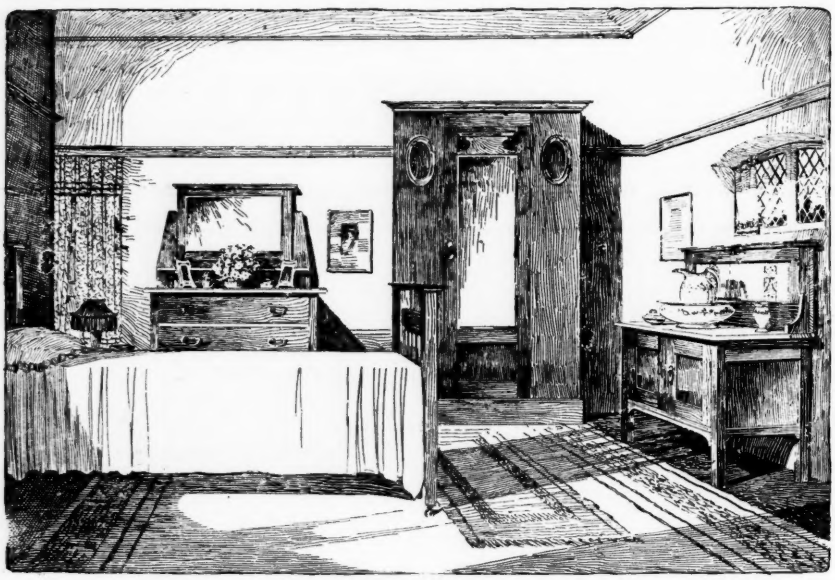

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THE MEDICAL JOURNAL OF AUSTRALIA.

VOL. I.—7TH YEAR. SYDNEY: SATURDAY, JANUARY 3, 1920. No. 1.

An Address.[1]

By **A. Sutton, C.B., C.M.G., V.D., M.R.C.S., L.S.A.,**
Retiring President of the Queensland Branch of the British Medical Association.

Being called upon by the effluxion of time to lay down my office, my first words to you must be of the thanks I feel for the great honour you paid me a year ago in electing me your President.

After my long absence your reception was very kind; to this kindness you added the honour of your presidency and I thank you, gentlemen, from the bottom of my heart.

The War.

The Council's work has been heavy and continuous, but our meetings have been a pleasing experience and I have to thank the members of the Council for their genial forbearance with all my shortcomings. The year that closes for the Association has been an eventful one. Peace was signed on June 21 and the great war was concluded by a peace which brought honours and glory to the British arms. It must be a pleasing thought to us all that so many members of this Branch gave their services so freely and helped to bring about this happy consummation. In the field, in the hospitals and at the base our members have given of their best. Many honours have been bestowed on them and, speaking from personal knowledge, I have no hesitation in saying they were richly deserved.

Some were not able to take part in active service abroad and yet they, too, have played an important rôle in caring for the soldiers' relatives and in helping on the returned soldier to repatriation. I speak feelingly of the enormous work performed by the profession on medical boards and in the treatment of the sick and wounded, for, as you know, in my capacity of Principal Medical Officer, it has been my duty to call you up at all times and seasons, whether convenient to you or not. Our profession has borne these sacrifices nobly; no other calling has shown such devotion to duty for so little return and I feel that medicine has added to the traditions of the past and has shown to the world a shining example of devotion and patriotism. One hundred and five medical officers went overseas from the First Military District and eleven of these made the supreme sacrifice.

The names of Luther, Richards, Buchanan, Hammond, Plant, Douglas, Bean, Money, Henderson, Metcalfe, Bailey and South will live in our memory, even though we have no honour board upon our walls. Let us for a moment stand in silent homage to our dead and thank God that He endowed these men with the gift of knowing the call to duty and of responding to it to the last.

The Epidemic of Influenza.

In the *Government Gazette* of May 3 Queensland was declared infected with epidemic influenza. Many of us had reached this conclusion before this date, but our Government was loath to admit it. Our Branch was invited to assist in minimizing the incidence of the disease and at once responded. The Council met the Home Secretary and the Commissioner of Public Health on several occasions and made strenuous, and I think I may claim, successful efforts to limit its spread, to prevent panic and to inoculate the people. The Council became an advisory body to the Government, met at all hours and devoted much time and thought to assist the Government in its arduous task. I regret to say the results were not satisfactory to the Branch.

Whenever repressive measures and irksome restraints were imposed on the general public the Queensland Branch of the British Medical Association was held responsible. Our recommendations, as a whole, were not adopted, nor were they published in full, yet when the danger was over and the time arrived for the removal of restrictions, action was taken without the advisory body being consulted.

Gentlemen, I regret to say it, but I do most emphatically assert that, should the Queensland Branch ever be called upon again to give the Government gratuitous advice and assistance, it is my opinion their best course would be to decline to do so.

The Work of the Council.

With regard to the government of our Branch, the past year's experience has shown me that your Council is too heavily weighted with work to perform its duties satisfactorily. After the day's task of professional work is done, to meet and spend three hours, or even more, in Council does not lead to wise, clear-cut and sound decisions. I consider the Branch would be taking a progressive step in increasing the personnel of the Council and in inaugurating standing sub-committees to deal with the special subjects which are continually brought before it.

For instance, a standing committee on ethics would have ample opportunity for work and should be able to arrive at decisions which would prove acceptable to the profession as a whole. I have no hesitation in saying this is impossible under present conditions.

During the year the advisability of drawing up a medical bill was carefully considered, but it was decided, after much thought, that the time was inopportune. Our Act, bad as it is, proves a workable one and the Home Secretary cannot order the registration of a medical practitioner. I doubt very much if a bill would prove acceptable to the Government unless a clause of this arbitrary nature were inserted.

Recently the Branch brought up a scheme for the reform of the method of appointing the medical staff of the Brisbane General Hospital. This was duly presented to the Government by a deputation, which met with a cool reception. However, I have reason to believe that some measures will be adopted as the outcome of our efforts which will relieve some of the glaring anomalies of the present unsatisfactory state of affairs.

[1] Delivered at the Annual Meeting of the Queensland Branch of the British Medical Association on December 5, 1919.

We are living in troublous times and the outlook of the medical profession is not so bright as it should be. The increase of wages to all operatives and the increased cost of living are steadily progressing in an upward direction and it follows that a greater expenditure on our part is necessary to maintain ourselves in reasonable comfort. Unhappily, there is no corresponding increase of medical fees and the man in the street cannot or will not see that such a corollary should be the outcome of the present economical situation.

One of the most onerous duties the medical practitioner has to perform is to draw up the certificate required by the *Insanity Act of 1884*. The public look upon this as a privilege and regard the power most jealously; yet the fee remains one guinea, as in 1884, when the purchasing power of that fee was nearly twice as much as it is to-day. Again, the fee for a medical witness in court still remains as it was forty years ago, notwithstanding the fact that all that the fee will purchase now has reached 50% or 60% in price. These fees are quite inadequate and therefore unjust; why should we not have the courage of our convictions and say so?

Future Action.

There is a widespread feeling among us that to consider these questions is undignified. I make bold to say that we must consider them and take action before it is too late. I hesitate to advocate the methods of the trades unions so rampant in Australia, but I do urge that it is essential we should, by union and determination, insist upon an equitable remuneration for our services. Were not the motor-car pressed into our service it would be impossible to carry on at the old rate of remuneration and I fail to see why we should not benefit by the improvements in mechanical science and have more leisure for study and recreation. At present the internal combustion engine enables us to do more work and so we maintain our incomes; it has not helped us to increase them, in spite of the fact, as I said before, that everything we buy costs so much more.

The latest legislation in Victoria and the proposal to enforce the *corvée* on medical men clearly show how necessary it is for the profession to fight for reasonable conditions of work, and my parting advice is, let us fight with all the weapons available, but let us fight generously and honourably.

It now affords me great pleasure to make room for my successor, Sir David Hardie, one who has ably filled this chair in the past and has had a long experience in the Branch, one whose counsels in the future will, I am sure, be of the greatest value to us all. I wish him success in his year of office and know that he will lead us wisely and well.

SOME REMARKS ON THE RESULTS AND TREATMENT OF YIELDING OF THE SUSPENSORY APPARATUS OF THE FEMALE PELVIC ORGANS.[1]

By **T. G. Wilson, M.D., Ch.M. (Syd.), F.R.C.S. (Ed.),**
Honorary Gynæcological Surgeon, Adelaide Hospital.

I have headed my remarks in this manner in order to deal with displacements generally, rather than with any particular type. The more one has to do with these cases, the more one is impressed with the fact that from a student's point of view, at any rate, the ordinary nomenclature in text books is misleading. The average student will talk about a retroversion, a cystocele and rectocele or a prolapse and in my experience is far too apt to look on each of these as a separate entity, according to the actual position of the uterus, rather than realizing that the essential feature has been the giving way or stretching of some part of the supports of the genital canal, which has allowed the uterus to assume its abnormal position. For a number of years before the war I had been teaching the students under me to look on these displacements in the way I now present and had made rough notes for this paper before going on service. I am not claiming originality for these views, as for a number of years various writers in the gynæcological journals have been emphasizing one or more of the essential features and different forms of operative procedure, especially in regard to what I shall speak of as the middle supporting group of the genital canal, have been described, especially by Polk, Alexandroff, Tweedy and Mackenrodt. While working at the Chelsea Hospital for Women in London recently, I had the opportunity of discussing this subject and of seeing some of the operative work of Dr. Victor Bonney, who has written extensively on these lines.

Looking at this subject from this point of view, the actual position of the uterus is more or less accidental. What really matters as regards treatment is to realize that some portion of the apparatus that keeps the uterus in its ordinary place, has given way, either as the result of the trauma of childbirth, or the overstretching or atonic condition of these supports from some other cause. A *prolapsus uteri*, for instance, is not a condition where the uterus has actively fallen, but it has been allowed to fall because its normal supports have given way. And more than this, in some cases, as for instance in cases of relaxed outlet, the uterus may have in the first place for a time at any rate actually acted as a suspensory ligament in holding up and preventing the eversion of the vaginal walls that ordinarily occurs first in this displacement. From a practical point of experience one knows that the condition so described is often treated by some form of ventro-suspension or ventro-fixation, without anything being done to relieve the want of support from below. It is in these cases that a recurrence of the condition is likely to occur. Again, occasionally a case is seen where the condition of complete prolapse has been treated by vaginal or abdominal hysterectomy, apparently on the assumption, "no uterus, no prolapse." Unless the stretched supports, especially the middle group, have been tautened up at the same time as the operation, the plight of these patients may be worse than before, as the stretched supports may and do allow the remaining pelvic organs to prolapse more extensively than when the uterus was *in situ*. It has seemed to me that a more general realization of this broader outlook on the whole subject of displacements may help to put the treatment of these conditions, operative and otherwise, on a more correct and rational footing.

[1] Read at a Meeting of the South Australian Branch of the British Medical Association on October 30, 1919.

Classification.

First of all it is necessary to consider what are the structures that keep the genital canal in its normal place. For this purpose the genital canal may be divided into three portions: (1) the upper portion, the uterine body; (2) the middle portion, the cervix and upper part of the vagina; (3) the lower portion, the lower two-thirds of the vagina.

The upper portion of the genital canal, *e.g.*, the uterus, is normally supported and kept in position by the broad ligaments and all that is contained in them, round ligaments, infundibulo-pelvic folds, ovarian vessels and the perivascular sheaths round them and the parametrium generally. The middle portion of the genital canal, *e.g.*, the cervix and upper part of the vagina, is normally supported by the lateral cervico-pelvic or Mackenrodt's ligaments, the utero-sacral ligaments and the uterine vessels, with their perivascular sheaths and the connective tissue binding the cervix and upper part of the vagina to the bladder.

A number of names have been applied to the structures here called lateral cervico-pelvic ligaments and a good deal of discussion has arisen as to whether these structures should be called ligaments. It is not intended to enter into this discussion, but about the strength and reality of the fibro-muscular bundles of tissue that do support this portion of the genital canal there can be no doubt, nor can there be any question about the operative results obtained by restoring this group of supports in cases of prolapse due to this cause.

The lower portion of the genital canal, *i.e.*, the vagina, is normally supported by the pelvic floor proper, the *levatores ani*, triangular ligaments, *transversus perinei*, the connective tissue and fascia attached to these and the perineal body.

Yielding or over-stretching of one or more of these groups of supports gives rise to all the various displacements of the female pelvic organs that are met with and a correct interpretation of the group or groups most at fault in any particular case and a knowledge of the best method of restoration of or substitution for this support will give the best treatment for each case.

It must be remembered that the giving way of one group of supports will naturally throw more strain on the other two groups; this is the indication for early restoration or substitution.

These groups may be taken in order.

(1) Yielding of the Upper Group.

This gives rise to the various degrees of retroversion of the uterus. This may occur quite suddenly as a result of overstrain, but generally speaking it occurs more gradually, as after a confinement or miscarriage, when all the pelvic supports are relaxed and in a state of subinvolution. And though it is possible to get what is often spoken of as a prolapse of the uterus with the uterus still in a forward position, *i.e.*, at right angles to the axis of the vagina (as will be mentioned in speaking of giving way of the middle group of supports), the uterus is usually in retroversion in the first stage of a prolapse, *i.e.*, in the same axis as the vagina.

The yielding of the upper group of supports is very common and may be divided into two classes: those with symptoms from the displacement and those without. While admitting that in a large number of these cases the symptoms complained of by the patient are due rather to the complications present than to the displacement itself, there are definitely uncomplicated cases in which symptoms referable to the displacement occur and which can be cured by curing the displacement. Amongst these I would especially mention patients who complain of sterility. At one time I was inclined to think that the curettage that accompanied any operative treatment for such cases probably accounted for the fact of so many of these patients becoming pregnant after rectification of the retroversion. But talking over this subject with the late Dr. Maynard Pain, who was attached to a Missionary Hospial in Egypt, and later seeing some of his patients, convinced me that probably as many of these women became pregnant after rectification of the retroversion and the insertion of a pessary as if they had been curetted.

The Egyptian married woman must have children if she is to retain her position in the favour of her husband and operation of any sort is taboo. In these cases Dr. Pain would simply put the uterus in place and insert a pessary; he assured me that the success of this treatment was remarkable and that one such successful case often brought a large number of sterile women from that particular village for similar treatment. Then there is no doubt that sometimes the condition of retroversion is congenital and the explanation suggested by Sturmdoff that the retroversion is secondary to skeletal changes, seems quite a feasible one. Moreover, it is one that is capable of demonstration and this may be of use in deciding whether treatment is desirable or not.

But many patients with a retroversion without symptoms develope symptoms referable to the displacement, if for any reason their general health gets below par, as after a severe illness or mental worry; the condition seems comparable to those of errors of refraction, which may be present for years without symptoms, but which require treatment under conditions of ill health. When complications, such as endometritis, etc., are present, the condition is more easily cured after the displacement is rectified. I have not considered retroflexion apart from retroversion, as the former condition after all depends on the degree of consistency of the uterine body.

(2) Yielding of the Middle Supporting Group.

Giving way or overstretching of these supports allows the cervix and upper part of the vagina to sag; this permits of an inversion of the vagina from above downwards. Here intra-abdominal pressure causes the vagina to become inverted and the cervix with the upper inverted part of the vagina may come right down to the *introitus vaginæ*. It appears as if there is present an immense lengthening of the cervix, but there is very little if any increase of the length of the uterine cavity as demonstrated by passing a sound; and the perineum may be quite intact.

In such a case, when the cervix is pushed up, the inversion of the vagina is unrolled and the apparent elongation of the cervix proper disappears.

In this type of case there has generally been a considerable laceration of the cervix, but it also occurs in nulliparous women and in virgins.

(3) Yielding of the Lower Supporting Group.

This is one of the commonest variety met with as a result of actual laceration or overstretching of this group of supports. It results in eversion of the vagina, causing cystocele and rectocele, but here the eversion of the vaginal walls is from below upwards and, according to the wall, anterior or posterior, more affected, there occurs greater cystocele or rectocele.

I have dealt with the giving way of each group of supports separately, but naturally the condition in any case may be the result of any combination of these groups that have given way. When the whole three groups have given way, there occurs the condition that is properly spoken of as complete prolapse of the uterus.

An estimation of the amount of yielding that has occurred in each individual case is necessary in order to treat the case efficiently. For instance, one of the commonest types that is met with, is where there is yielding of the upper and lower groups of supports, resulting in a retroversion of the uterus with some degree of eversion of the vaginal walls, meaning simply that the middle supporting group, which is probably the strongest supporting group of the genital canal, has not given way and the cervix retains relatively its normal height and, as one would expect, if this condition be allowed to persist, the middle supporting group may eventually yield and the condition of complete prolapse result.

While it is not necessary to go over all these combinations individually, I would like to make a point of the two varieties which give rise to the common complaint of "something coming down in the vagina." I refer to the condition that occurs as the result of stretching of the middle supporting group and as the result of stretching or giving way of the lower supporting group.

In the first case the cervix may definitely protrude from the *introitus vaginæ* and yet on examination, there may be little or no cystocele nor rectocele present. The supports of the middle group have allowed the descent of the cervix and upper part of the vagina, which has been everted from above downwards. Naturally this is more likely to occur when the upper supporting group is also at fault.

In the second variety the giving way of the lower supporting group has allowed the vaginal walls to be everted from below upwards.

On replacing the uterus in these two varieties of prolapse the mechanism can quite easily been seen to be different and the treatment required also is different. Naturally if the condition has persisted long enough, the one variety will run into the other and there occurs an eversion of the complete vagina. In cases where the *fundus uteri* has been fixed to the abdominal wall and there is yielding of the middle supporting group, there may occur an actual lengthening of the supravaginal cervix, but this condition differs from that already mentioned where there is an apparent lengthening of the cervix proper, which disappears when the cervix is pushed up and the inverted vagina is made to unrol. In all these conditions the patient's general health has to be taken into account and quite frequently one notices that a patient may not complain of prolapse till the supervention of some illness, or at the time of or after the menopause, when the loss of tone that takes place in fibro-muscular tissue with advancing age allows of the gradual yielding of one or more groups of supports that have hitherto performed their function efficiently.

Treatment.

On general lines the aim of treatment will be either by the restoration of the normal torn or relaxed supports, or by the substitution of some other support for those. In operating for stretching of these groups of supports and particularly of the lower group, the principle of overcorrection must be observed, as the supports have, as a rule, permanently altered in character and resiliency before coming to operation. Our aim should be to leave the supports at the end of operation rather more taut than they were before parturition.

(1) Yielding of the Upper Group of Supports.

Here I would start by saying that restoration does not necessarily mean operation. In post-puerperal and post-abortion cases of retroversion the putting of the uterus back to its forward position and possibly the insertion of a suitable pessary will be effective in a large proportion of cases. I am convinced that if all such cases were so treated within the first 6 or 8 weeks after confinement or abortion, there would be less need for operative interference later on.

The assumption of the genu-pectoral position twice daily where the uterus is found to be in retroversion and subinvolution within a month after confinement has in my experience been sufficient in some cases. If this is not the case, the insertion of a suitable pessary for a few weeks is needed to keep the uterus forward till the supports have had time to regain their normal tone.

Combined with this, general physical gymnastics for the abdominal muscles, which the patient can quite easily be taught to do herself while in bed, and possibly abdominal massage will be of definite help, beside helping the regaining of the patient's figure after confinement, which to the patient may appear at the time more important than the position of the uterus. I do not wish to be considered as an advocate of pessaries as a permanent treatment. They should be looked on in these cases as a purely temporary measure and if the normal supports have not regained their tone within a few months and the condition requires treatment, I would definitely advise operative interference. But as a temporary measure I do think that the danger from a foreign body in the vagina can be sufficiently minimized to make it worth trying this before resorting to operation. I have convinced myself that in a large number of these cases operation can be avoided.

In this regard I may say that I have definitely thought that subinvolution and consequently retroversion after confinements was rarer in those patients who had been allowed to sit up and get up early, rather than being kept on their back during the whole lying-in period. But this does not mean that I allow a woman to get back to her routine house-

hold work after confinement one day earlier than under the old routine.

I think the above remarks apply more to cases of retroversion, the result of relaxation of the supports in pregnancy, as in my experience those cases of retroversion that occur in nullipara suddenly or as a result of strain or after debilitating illnesses, are not as a rule curable with a pessary, as the supports do not seem to recover their tone; in the involution of post-puerperal cases and if symptoms are present, operation is indicated.

Treatment by pessaries generally for these cases can be dismissed with these remarks. Apart from certain women who, on account of age or inability to stand an operation, their use as permanent treatment is not advisable. At best they act by substitution and except for the cases indicated, they are merely palliative and not curative.

Operative Treatment of Yielding of the Upper Group.

For practical purposes the broad ligaments are rendered taut by some form of shortening of the round ligaments. The ordinary Gilliam operation as originally described, I do not like, as it leaves a potential condition where strangulation of the bowel inside the peritoneal cavity may occur. I have always adopted the modification described by Noble, in which the shortening of these ligaments is done extra-peritoneally. In ordinary cases I generally employ the transverse incision of Pfannelstiel and stitch the round ligaments with chromic gut to the posterior aspect of the aponeurosis of the rectus. The Alexander-Adams operation is quite effective as regards restoring the uterus to its normal position, but personally of late years I find I am doing this operation less frequently, because I feel less certain of any possible complications. The modification suggested by McKay and Goldspohn appears to me to be involving two sections instead of one. Baldy's operation is effective and has the advantage of raising up the level of the cervix and is useful in those cases where there is a lengthening of the middle group of supports.

Ventro-suspension and ventro-fixation I have not used in these cases for many years in a woman of child-bearing age, because of the possibility of dystocia afterwards. I think that this possibility was more likely when Kelly's method of ventro-suspension or ventro-fixation of the posterior surface of the uterus was more in vogue than it is at present. Suspension or fixation of the anterior surface of the fundus of the uterus is probably not nearly so objectionable. But in the treatment of women who will not again become pregnant, either because the menopause has been reached or because the ovaries or tubes or both have been removed, I think these are the operations of election, especially if there it stretching of the middle and lower group of supports as well. Generally speaking, a retroversion or retroflexion after the menopause does not give rise to symptoms, unless complications are present and, therefore, does not requre treatment.

(2) Yielding of the Middle Group of Supports.

This type of prolapse is generally complicated by laceration and eversion of the cervix and may require plastic work and possibly amputation of the cervix. The lateral ligaments of Mackenrodt are best and most effectively shortened by some such operation as that of Alexandroff, in which these structures are stitched across the front of the denuded cervix after the bladder has been separated and pushed upwards. Polk advises the shortening of these structures (the middle group of supports) from above. He performs abdominal section and carries out the shortening after separating the bladder from the cervix. The result of the operation done either from below or above is to render these lateral supports taut and at the same time to keep the cervix back in the hollow of the sacrum. In cases of pure cystocele, occurring generally in elderly women, the vaginal operation combined with tier suturing of the anterior vaginal wall, gives excellent results.

The shortening of the utero-sacral ligaments, either by the vaginal or by the abdomen route, also has the effect of keeping the cervix back in the hollow of the sacrum, but I have not often found this procedure necessary when the latero-cervical ligaments have been dealt with. If plastic work is required for the cervix, these structures can be shortened at the same time. The method advocated by Inglis Parsons of injecting quinine into the base of the broad ligaments gave good results in his hands and acts by causing a plastic inflammation and later a fibrosis of these structures. It is therefore a logical procedure for prolapse due to stretching of this group of supports. When a complete prolapse has been present and a panhysterectomy has been done for any reason, the middle group of supports may be rendered taut by stitching together the bases of the cut broad ligaments. This will prevent the eversion and prolapse of the vaginal walls that may otherwise occur in such a case.

This procedure illustrates very well the holding up that can be obtained from this group of supports. Such a procedure as was mentioned previously of removing the uterus for prolapse with the idea of curing the condition is merely indicative of a want of appreciation of the structures that keep the cervix and vaginal vault in position under normal condition and of the causes of the uterine prolapse.

(3) Yielding of the Lower Group of Supports.

The various operations for the repair of the posterior vaginal wall and perineum all have the same effect, *viz.*, the restoration and tightening of the lower group of supports, especially of the *levatores ani* and the bringing together of the pubo-coccygeal portion of these muscles in front of the rectum. Provided these points are attended to, the functional results of such operative procedure are good.

Yielding of all groups of supports, resulting in the condition of complete prolapse of the uterus, must be dealt with by restoration of, or substitution for, all the supporting groups of the genital canal. In severe cases the question of whether it is wise for the patient to be allowed to run the risk of subsequent pregnancy must be considered. If pregnancy is not to take place again, a ventro-fixation with a broad surface of the uterus approximated to the abdominal wall will give the strongest hold; this, with the necessary plastic work for the middle and lower groups of supports, will be sufficient. This means a long

operation for one sitting, but if all supports are relaxed, all must be restored. In such cases I have been accustomed to do a Baldy's operation at the same time as the ventro-fixation, especially if the middle group of supports has been badly relaxed.

If pregnancy remains possible, the ventro-fixation is naturally omitted and the uterus kept up by shortening the round ligaments by one or other of the usual methods; the middle and lower groups of supports are dealt with as described. In some of these cases I have divided the round ligaments in their middle and have done a Baldy's operation with the distal portion, or stitched this portion to the back of the uterus and carried out a Noble's modification of Gilliam's operation with the proximal portion. Both these operations give a double support on either side by the round ligaments, structures which will involute with the uterus after pregnancy and, as these ligaments are generally well developed and long in such cases, it has seemed a double security.

If the *fundus uteri* is removed, the cervix can either be ventrofixed or the round and broad ligaments stitched to the cervix. For all these stichings I am accustomed to use No. 3 (20- or 30-day) chromic gut. In cases where the middle supporting group is badly overstretched and difficult to restore efficiently, it may be wise deliberately to amputate the uterine body in order to get a firmer attachment by ventrofixation of the cervix. Here I rely on substitution rather than restoration. Bonney suggests in such cases that the ventro-fixation should be carried out very high up on the abdominal wall, thus making the uterine body a suspensory ligament. There are a number of other operations described for cases of complete prolapse, which also come under the heading of substitution for, rather than restoration of, the normal supports. That described by Wertheim of interposing the uterus turned upside down between the bladder and anterior vaginal wall and Le Fort's operation of making a double vagina with the idea of preventing eversion of the vaginal walls may be mentioned. The latter has a limited sphere of usefulness in cases of eversion of the vagina after hysterectomy, where the middle group of supports has been stretched beyond restoration. There still remains the treatment of those cases of complete prolapse in old women who are either not fit subjects for operation, or who refuse all operative interference. Here, again, we are thrown back on various forms of pessaries or mechanical supports. Of these I think the best is the cup pessary with a flexible rubber stem. One patient has to my knowledge worn one of these for 15 years with relief of her symptoms. Fortunately the number of these cases is small and the weird and wonderful forms of support that were once used, are not often seen now-a-days.

THE ABOLITION OF THE DRAINAGE TUBE IN THE OPERATIVE TREATMENT OF HYDATID CYSTS.

By **W. J. Stewart McKay, M.B., M.Ch., B.Sc.,**
Senior Surgeon, Lewisham Hospital, Sydney.

By the title of this paper it might be supposed that I imply that no hydatid cyst should be drained. I hope to make it clear that I do not mean that. What I do mean is that the drainage tube ought to be discarded in many of the operations on hydatid cysts in which it is employed as a routine part of the technique of the operation.

If we glance at the evolution of the operative treatment of hydatid cysts, we shall see that, after the epoch-making operation performed by Lawson Tait in 1880, in which he opened the mother cyst of a liver hydatid, removed the endocyst and numerous daughter cysts and attached the rim of the adventitious sac to the edges of the abdominal incision and inserted a drainage tube, this method of operating became the recognized procedure. We may remark, *en passant*, that while Tait introduced this operation to English surgeons, it is to Lindemann that we must give the credit of priority of execution, for he carried out the same operative procedure as early as 1871. Tait, however, knew nothing of his work, which was not made known until Kirchner published an account of the method in 1879.

In 1883 Knowsley Thornton published his method of dealing with a hydatid cyst of the liver; he removed the endocyst and then sewed the edges of the adventitious sac to the abdominal incision and closed the latter without inserting a drainage tube.

Later on Bond, in 1891, in dealing with some hydatid cysts of the general peritoneal cavity, found that as he could not drain one of the cysts, he opened it, removed the endocyst and returned the adventitious sac to the peritoneal cavity with success.

In 1898 Posadas, after removing the endocyst of a liver hydatid, closed the opening in the adventitious sac and dropped the liver back without fixing the adventitious sac to the abdominal incision.

About the same time Delbet successfully applied sutures to close the cavity left after the removal of the endocyst, by causing approximation of its opposing surfaces and then closed the abdominal incision without fixing the liver or the adventitious sac to the abdominal wall.

Lastly, several surgeons have, in selected cases, excised hydatid cysts and have closed by sutures the gap left in the liver substance.

With regard to the above procedures one may admit at the outset that the Lindemann-Tait operation is the one that is most generally employed and that it is the most useful and probably the safest; but what I want to urge is that many cases of hydatid cyst of the liver need not be treated by the above method and that drainage is unnecessary and harmful, inasmuch as it is followed very often by suppuration of the cyst cavity.

Knowsley Thornton, who was a very successful surgeon in those early days when Listerism was making but slow progress in London, was one of the first surgeons to use Listerian precautions with success in abdominal surgery; it was owing to this fact that he was able to deal with his case of hydatid cyst successfully. Let us hear what he says:—

> I sewed the whole opening in the cyst into the abdominal incision and, having taken care to thoroughly dry the sac, closed it up entirely without introducing a drain of any kind. This was an experiment, but it seems to me that, when once thoroughly cleaned of hydatids, the sac would not be a secreting one, as it had not suppurated, and if a little serum was effused into the cavity, it would gradually reabsorb as the sac contracted.

Now this very sensible experiment was made some thirty-six years ago and yet many surgeons in the present day in Australia refuse to benefit by Thornton's successful experience.

Let us ask the question: Why was Thornton successful? I think the answer is contained in the following facts:—

(1) He used Listerian precautions during the operation.
(2) No bile canaliculi communicated with the cavity of the adventitious sac.
(3) There were no septic conditions present in the hydatid cyst at the time of operation.
(4) There were no daughter cysts.

These four conditions are necessary if we wish to treat a hydatid cyst of the liver without drainage. There are some who will add that calcareous patches must not be present in the walls of the adventitious cyst. I certainly admit that when they are present, they are liable to act as foreign bodies and may be the cause of a fistula at a later period.

I shall now give the details of the operation that I have practised many times during the last ten years since I determined to give up the drainage tube.

The skin is cleansed for two days at the seat of the operation with hot packs of biniodide of mercury and, as soon as the incision is made in the skin and fat, gauze is fixed along the edges of the wound. I lay the greatest stress on this detail, for I maintain that the majority of hydatid cysts of the liver that are operated on are quite sterile at the beginning of the operation, but become infected by the surgeon's defective technique during the course of the operation. If there is one lessen above another that I have learned from performing some 3,000 abdominal sections, it is this, that when a section lasts for more than fifteen minutes, it a wise precaution—I almost say a necessary one—to attach gauze to the edges of the incision. So here at the outset of our operation on a hydatid cyst we must first try to eliminate infection from the skin surrounding the incision. After reaching the cyst I always insert an aspirating needle and draw up a little fluid. If it is perfectly clear and "gin-like," I take it that there are no daughter cysts and straightway insert sutures into the wall of the adventitious cyst, on either side of the spot where I am about to make my incision. If, however, the fluid is cloudy, or very little fluid can be drawn up into the syringe, I consider this an indication of the presence of daughter cysts and proceed to insert several sutures into the adventitious sac, so that the sac may be drawn right up to the abdominal incision to prevent the escape of the daughter cysts into the general peritoneal cavity. After the endocyst has been removed and all fluid, or daughter cysts, cleaned out with various sized spoons, the walls of the adventitious sac are cleansed with peroxide of hydrogen. If the sac is a small one, I simply pour in the peroxide and leave it for some time and then insert a metre or more of plain gauze, about 2.5 cm. wide, to dry the sac as thoroughly as possible; this is then withdrawn. The sac is attached to the abdominal incision, the catgut passing through the peritoneum, muscles and aponeurosis, but not through the skin. Then the surfaces of the incision are washed with undiluted peroxide of hydrogen and the abdominal wall is closed over the opening of the attached sac. The wound is dressed with plain gauze soaked in carbolic solution (5%) and, as a rule, no further trouble arises; no patients have died.

This operation can be carried out on all clean cysts, while a cyst whose walls are excessively thick, are hard and contain calcareous patches, can also be treated by the above plan, for we must remember that in Thorton's successful case he remarked that the walls of the adventitious sac were calcareous in parts. Should anything go wrong after the operation, all that is necessary is to take a few of the skin sutures out, to place a drainage tube in the cyst and to drain and irrigate it until the temperature falls. Any cyst which contains pus must be drained and irrigated daily.

If a bile canaliculus opens into the cavity, the bile poured out will gradually fill the cavity of the adventitious sac and will make its way out at the abdominal incision. In these cases if we keep the wound dressed with gauze soaked in carbolic solution, we may have the satisfaction sometimes of having no infection, but I admit such cases are not favourable for the method, yet they should be given the opportunity of being treated without the drainage tube, which always invites suppuration. If at the time of the operation we are fortunate to detect the spot from which the bile is being discharged, it may be possible to close the orifice of the duct by inserting some sutures; this was successfully done by Delbet in one of his operations.

Charles MacLaurin in his classical paper on hydatids tells us that "the liver may contain organisms from the portal system which may become extruded into the vacant cyst cavity." This would not deter me from practising the method I am advocating, because if the patient's temperature should rise and the chart indicate infection, a few skin sutures can be removed, a tube inserted and, if necessary, the cyst washed out.

Coming to the question of washing out the cyst as part of the technique of a hydatid operation, I refrain from doing this unless daughter cysts or pus is present. If daughter cysts are found in a large cyst I used to expect that I should have to insert a drainage tube at some part of the treatment, because I found that if a number of daughter cysts were not removed from the cyst cavity, sooner or later, suppuration began. I accordingly adopted a plan for irrigation which has proved very successful in these cases. I had made a metal box 180 cm. long, 75 cm. broad and about 15 cm. deep. The upper part, upon which the patient rests, consists of four or five metal bars placed about 30 cm. apart. When the time comes for irrigation, the zinc box is wheeled into the theatre resting on a trolly and the patient is lifted on to the metal bars, the chest and legs are covered with blankets and the irrigation is begun. The fluid is forced into the cyst cavity and the patient can be turned and rolled on the metal bars and, as the fluid escapes into the box below, litres of irrigating fluid can be used without causing the least mess, while the irrigation is continued until there is no sign of any daughter cysts. The cavity is then dried out by

the introduction and withdrawal of a large quantity of plain gauze. The peroxide is then introduced and it in turn is dried out and the skin is closed over the mouth of the adventitious sac.

In one case in which I adopted this plan the patient was able to leave the hospital within three weeks of the operation. After being at home for some weeks I received a most irate letter from the husband of the patient, saying that the wound had burst open and that hundreds of cysts were being discharged. The explanation was, of course, quite obvious; there had been a second cyst that I had missed and it had burst into the adventitious sac cavity that I had refused to drain.

In regard to Bond's operation, that is, the treatment of cysts in the general peritoneal cavity by opening the cyst, removing the endocyst and dropping the adventitious sac back, we have all done this so often that no one will attempt to say for one moment that this is not the proper procedure to adopt. Quite recently I operated on a woman who had seven cysts in various parts of the peritoneal cavity, each as big as a fist; I emptied each carefully, cleansed each with undiluted peroxide and returned the seven sacs to the peritoneal cavity. The woman did not show even a rise in temperature during the after treatment.

With regard to Delbet's operation I have nothing to say in its favour. Anyone who has had an extensive experience of hydatid cyst surgery, will know how absurd it is to endeavour to close the cavity of a large adventitious sac by sutures; such a procedure is about as ludicrous as trying to sign your name to a cheque through a key hole.

Lastly, I am not at all in favour of any procedures which have for their object the closing of the opening in the adventitious sac and then dropping the liver back. Such a procedure is attended by a risk which is averted by fastening the edge of the adventitious sac to the abdominal wall, as advocated above.

As regards excision of the entire cyst I have been able to do this but rarely and then only when dealing with small cysts. Recently I was called upon to operate on a long, bottle-shaped cyst, which hung down from the under surface of the liver in the mid-line. I thought that it was a favourable case for excision and I started with that object in view. All went well until I opened up a large vein; I thought that the patient was going to bleed to death on the table. I finally succeeded in stopping the hæmorrhage by packing gauze in between the cyst wall and the liver substance; then I cut away as much of the wall of the adventitious sac as I could and washed what was left; I then fixed it to the abdominal incision and closed the abdominal wound, only leaving the gauze protruding. This was removed after a few days and everything went well.

I might remark that last year I treated a hydatid cyst of the lung in the same way as I have described above. I did not drain and all went well; only a small amount of fluid came through the incision about ten days after the operation.

Let me conclude these remarks on the operative treatment of hydatid cysts by a few observations on fistulæ which remain as a result of the drainage treatment of the endocyst.

Many methods have been tried in the endeavour to close a persistent sinus. I frequently failed until I hit upon the following simple plan.

For some days before the operation I have peroxide of hydrogen injected into the sinus; then at the time of operation I dilate the sinus by means of straight metal Hegar dilators, which I have graduated to correspond with the graduations of the French scale of catheters. This gives such a gradual increase in size that, provided the smallest size can be introduced, no difficulty will be found in pushing in the others. When the sinus is sufficiently dilated, the whole tube is filled with peroxide of hydrogen and a long strip of very narrow gauze is packed into the sinus. An incision is made in the scar of the original incision, starting about 2.5 cm. from the sinus. This cut approaches the sinus; it then surrounds it in a circle and is continued in the original incision for 2.5 cm.. The dissection is carried on through the scar tissue surrounding the sinus; several scalpels are necessary, for the scar tissue takes the edge off the knife in a very short time. The dissection goes on slowly, because the scar tissue bleeds excessively and obstructs the view, but gradually the sinus is approached. It is easily recognized by the gauze packing and the dissection is carried on round and round the sinus until we have progressed 5 cm. or more. By this time the sides of the sinus with its gauze centre give way and the tissue tube stuffed with gauze is removed. It is useless to continue the dissecting further; all that is necessary is to wash the cavity with peroxide and to pack it with gauze soaked with an emulsion, the formula of which is given below. The wound is packed each day with a narrow strip of gauze soaked in emulsion and at the end of three weeks the most obstinate hydatid sinus will be closed; at least, that has been my happy experience for many years.

Now as regards the emulsion mentioned above, the formula I picked up somewhere or other twenty years ago and I introduced it into the Lewisham Hospital. It has been in constant use for every kind of open wound ever since. It consists of 1.78 c.cm. of balsam of Peru mixed with 28.4 c.cm. of castor oil. I have poured this balm of Gilead on to the brain, into the abdominal cavity, down septic drainage tubes, on to fresh areas, as after removing the breast when the skin flaps will not meet, and always with a result that made me thankful to the man who first thought of this happy combination. I might add that when one is dealing with a surface that has been burnt, the addition of a little zinc oxide makes a most soothing dressing for the tender area.

It has been announced in the daily press that Dr. Clive Wentworth Thompson, D.S.O., M.C., formerly Lieutenant-Colonel in the Army Medical Corps, Australian Imperial Force, has been awarded the *Medaille de la Reconnaissance Française*.

The Health Bill of Victoria, which has been debated at great length during the past few months, was passed by the Legislative Assembly on December 23, 1919, the amendments suggested by the Legislative Council having been accepted. The measure now awaits the Royal assent.

Dr. Granville Waddy, late Captain in the Royal Army Medical Corps, has commenced practice as an ophthalmic surgeon at 227 Macquarie Street, Sydney, in partnership with Dr. F. Antill Pockley.

The Medical Journal of Australia.

SATURDAY, JANUARY 3, 1920.

A Retrospect.

(1.)

The science and practice of medicine, imperfect today, are the outcome of profound thought, unceasing endeavour and ingenious experiment. Progress follows the sum of newly-acquired-knowledge; stagnation is impossible when so large an army scattered throughout the whole world is striving toward a common goal. Since the ethical law of the medical profession is respected universally that discoveries and advances in knowledge must be imparted immediately and without reservation to the profession, the position of medical science can be ascertain more readily than that of any other applied science. Commercial and financial consideration impel men to keep secret newly-discovered facts in chemistry, engineering and the agricultural sciences; no personal motives are recognized as excuses for withholding knowledge relating to the nature, causes or treatment of disease. For these reasons we have instituted the practice of endeavouring to take stock at the beginning of each year of the state of medical knowledge and to pass in rapid review the more important events which have affected the practical application of medical knowledge.

Post-War Problems.

The cessation of hostilities and the gigantic task of transferring over 200,000 of our soldiers from the various theatres of war to Australia have brought with them many new medical problems. During the year 1919 we have learned afresh that unpreparedness is extravagant and often associated with irremediable consequences. Australia and the rest of the British Empire have stood facing dangers and disaster. The danger passed, we are but too apt to forget the warnings of the recent difficulties and mistakes and to ignore the lessons so dearly bought. Our Army Medical Service was born during the South African campaign and developed rapidly at first. A long succession of peaceful years caused the interest in the service to flag. It was left to a small handful of enthusiasts to struggle against apathy and indifference, until the organization lapsed. Even those who were prepared to keep our Army Medical Corps up to service trim, soon failed to grasp the essential changes which a progressive medical organization would encounter. Throughout the war we had occasion again and again to insist that the modern developments of bacteriological and pathological science were being neglected, that the practice of orthopædic surgery, of neurology, of epidemiology and of preventive medicine were not being placed in a favourable position by those in authority. The fault lay chiefly in the fact that before the war no one appeared to have planned a scheme for the application of modern medical knowledge to the circumstances of warfare on a vast scale. Perhaps no one had dreamed of the possibilities of a world war with all its ghastly accompaniments, the need for universal rationing and the necessity of pressing into the services every available expert to feed, clothe, arm, equip and doctor millions of combatants. These problems have been brought prominently before the medical profession during the short period since the armistice. The national medical services stand in need of reconstruction. They must be made attractive, so that men of undoubted ability may be tempted to lend their aid. The training must be adapted to the state of medical knowledge and those whose duty it will be to direct the activities of the services, must recognize that at any moment they may be called upon to mobilize their forces and to place in the field a service prepared to meet any emergency and to overcome the greatest difficulty that may have to be encountered. Moreover, we would emphasize the point that the onus of keeping an efficient service in readiness must not devolve on those who have already given much to their country. The others must come forward and do their share.

The Army Medical Corps of the future will have to be built up with the guidance of past experience. Many men have contributed something to the record, but no one has been able to grasp every detail. The pure surgeon is naturally inclined to regard military surgery as the prime objective of the service. The neurologist, the physician, the bacteriologist, the radiologist regard the problem from their own particular point of view. It is therefore necessary to

set up a broad basis of experience to guide the work in the future. Fortunately this help will be forthcoming. The War Records Section contains a medical department that will deliver the goods. Under the able direction of the official Collator, Colonel A. Graham Butler, D.S.O., recently returned from Europe, the staff of the medical department have gathered information to enable a medical history of the war to be written. The medical profession will be called upon in the near future to determine whether a popular history of the medical activities of the Australian army is to be prepared and published. We owe it to our fallen colleagues to raise this memorial to their fame. In addition, there is material ready to be used for the compilation of a history descriptive of the medical service from a military point of view. This history would serve as an ideal guide for the erection of a living medical service. Come what may, this technical history of the medical military machine must be written and widely distributed. In the near future we shall appeal to our readers to give their aid to Colonel Graham Butler, so that the work, so well begun, may be completed in a manner worthy of the immense traditions of our Army Medical Corps.

The year 1919 has seen but little change in the establishment of the Royal Australian Naval Medical Service. Last year we called attention to the excellent work of reconstruction undertaken and completed by Fleet-Surgeon A. C. Bean. More remains to be done in the future, but the foundations have been laid and the medical profession has the duty to remember that Australia has a Navy to safeguard her shores. That Navy must not fail for want of a fire-class medical service. No better way to keep alive our interest in our naval and maritime supremacy can be found than to join the Royal Navy League.

The medical profession has large responsibilities in connexion with the repatriation of our returned soldiers. A great deal of important work has been accomplished by medical practitioners within the Commonwealth. We do not hesitate to state that the organization of the Department of Repatriation is defective and that the most obvious defects are not being remedied as rapidly as is necessary. Important progress has been made in the provision for returned soldiers suffering from tuberculosis. At length something approaching a co-ordination scheme is being established. The introduction of the communal farm, referred to by Dr. Ramsay Webb in his thoughtful address to the members of the Victorian Branch, marks an important advance. Greater discrimination between early, curable infections and advanced or rapidly progressing lesions must be made before the scheme is complete. The year 1919 has witnessed the establishment of curative workshops or orthopædic treatment centres in all parts of the Commonwealth. While this step should have been taken years ago, we may record our gratification that it has been achieved at last. It may still be possible for the medical profession to seek those soldiers who were allowed to leave the army untreated and uncured, and to induce them to submit themselves to curative treatment before it is too late. Vocational training, too, has its medical side. We have urged in the past that before discharge the incapacitated soldier should be placed under the care of the expert orthopædic surgeon, with an expert vocational training officer to advise him. After the soldier has been discharged from the army, he should be trained by the vocational officer, with the medical expert ready to assist him. The appointment of a Director of Vocational Training for the Commonwealth has been a move in the right direction. Mr. James Nangle's task might have been made easier and more effective, had the hidebound regulations been more elastic and less rigid.

The medical profession in the Commonwealth has witnessed the sad spectacle during the year that is just gone of broken promises. In 1914 those who remained behind undertook, through the mouthpiece of the six Australian Branches of the British Medical Association, to preserve the interests of their absent colleagues. Our young and middle-aged and old members went forward to help in the great cause in their hundreds, relying on that promise. They have now returned and many find that their practices have not been kept intact. Some have received an aliquot part of the fees paid to the practitioners at home by their erstwhile patients; some have received nothing. Attempts have been made in many places and on many occasions to fill public positions by stay-at-homes without giving the men on active service a chance to apply for the posts and to obtain them, if their qualifications proved satisfactory. We have advocated for years that returned medical officers should be given

preference for these positions, "other things being equal." This phrase may be translated to mean that if the public can be served as efficaciously by a returned man as by one who did not go away, the office should be given to the former. So flagrant was the injustice meted out to returned men on many occasions, that it became necessary for some of the more prominent returned medical officers to establish societies in Victoria and New South Wales for the purpose of looking after the interests of returned medical men. This task should have devolved on the shoulders of those who had not been abroad. Human nature, alas, is too frail and, to paraphrase Oscar Wilde, man can resist everything but temptation. A correspondent has recently used the term "reward" when dealing with this subject in our columns. We trust that there are but few who did not pity the man who was so blind, that he could not realize that the only reward possible for the men who sacrificed everything to obey their country's call, is the consciousness of having done their duty nobly. Could a more inappropriate word have been chosen?

Years ago the proposal was made in South Australia that a fund should be established for the benefit of incapacitated medical officers, of the dependants of those who have fallen in the war and of those who need assistance to re-establish themselves in their civil practices. The year 1919 has seen the realization of this proposal. We have associated ourselves from the first with the scheme and we have advocated liberality in the contributions. The first lists were published in our columns on August 16. The amount subscribed has now reached a little more than £10,000, practically one fifth of the sum asked for. Very many men who could well afford to contribute relatively large sums, have not yet given. Many of those who have not been on active service and have reaped a rich harvest by staying at home, have contributed sums disproportionately small to their means and to nature of the fund. The entries in the lists have given rise to much criticism, not always of a flattering kind.

This chapter of our summary of the events of the year would be incomplete without a passing reference to the return of General Sir Neville Howse, V.C., K.C.B., Director-General of Medical Services of the Australian Imperial Forces. It is the universal wish of the medical profession in Australia that his services may be secured to direct the future of the Australian Army Medical Corps. He had earned the confidence of all who had the good fortune to serve under him. His unusual organizing ability and his large grasp of men and ideas should not be lost to the Commonwealth.

The British Medical Association in Australia.

Much important work has been conducted by the Federal Committee and by the Councils of the six Branches. One of the most urgent matters that have been considered is the extension of the public health service. The Federal Committee adopted a number of resolutions indicative of the directions in which this extension should be made. The Committee arrived at the decision that the Federal authorities should co-operate with the State Governments for the purpose of improving the methods of administration of health affairs. The resolutions passed by the Committee were handed to the Acting Prime Minister by the Chairman of the Committee. That these resolutions have arrested attention is manifest from the policy speech of the Prime Minister, delivered at Bendigo on October 30, 1919. The public is now made aware that the medical profession recognizes its responsibility to the community and is prepared with a constructive policy to improve the public health. The Federal Committee has taken active steps to obtain adequate provision for post-graduate study for medical officers of the Australian Army Medical Corps before demobilization. Unfortunately the responsible Minister has not conceded the demands of the Committee.

While all the Branches have spared no efforts to improve the relations between the medical profession and the public and have worked hard to this end, some of the endeavours have not led to an immediately satisfactory result. The Victorian Branch has continued to resist the political intrigues of the Friendly Societies' Association. Many of the orders have revealed a recognition of the justice of the claims put forward by the Victorian Branch. The chief difficulty appears at present to be centred around the so-called medical institutes, organizations set up hurriedly to enable the lodges to offer something resembling medical attendance to the members. It is apparent that these institutes cannot serve any

useful purpose and are tending to lower the standard of lodge practice. It must be quite obvious to the lodge members that they have a right to demand something better than they are obtaining. The foolish attempt on the part of the Victorian Government to ensnare returned medical officers into the positions of health officers under the new measure and to impose on them the duty of giving attendance to lodge members, is the expedient of a drowning man clutching at a straw.

The Tasmanian Branch is still marking time, while an unrepentant Government endeavours to cover up its mistakes by absurd legislation. The difficulty in Tasmania lies in the fact that the British Medical Association is determined to resist all attempts to open the public hospitals to rich and poor alike. As long as medical practitioners give their services in an honorary capacity, the hospitals must be reserved for the treatment of persons of small means who cannot afford to pay for medical treatment elsewhere. The hospitals in Tasmania are in need of reform and experience has taught us that the sick poor will look in vain for the proper kind of reform from the present Government.

The Queensland and the New South Wales Branches have performed important public service in calling the attention of the authorities to the menace involved in permitting medical practitioners of alien enemy origin whose conduct had necessitated their internment during the war, to remain within the Commonwealth. It is generosity gone mad to tolerate the continued presence of these men in our midst.

During the epidemic of influenza, the several Branches of the British Medical Association acceded to the request of their respective State Governments to come to the aid of the health departments. In some instances the advice given was not acceptable to the politicians and the Councils of the Branches were compelled to intimate to the responsible Ministers that they were not prepared to assist in such circumstances. The position was an extremely difficult one and the experience of the trying time has demonstrated the urgent necessity of divorcing public health administration from political control.

The Australasian Medical Congress.

At the Australasian Medical Congress, held at Auckland in 1914, an invitation was extended from Brisbane to hold the next congress in that city. The invitation was accepted and the Honourable W. F. Taylor was elected the President. The congress was to have been held in 1917. Early in the period of the war, it became apparent that the congress could not be held until peace was again restored. Preparations have now been made to hold the congress in Brisbane from August 23 to 28, 1920, and the various offices have been filled. We have recently distributed as a supplement to the *Journal* a preliminary announcement descriptive of the organization of the congress.

Public Health and Preventive Medicine.

During the early months of 1919 all the health departments in the Commonwealth were faced with an unusually difficult problem of endeavouring to combat a severe epidemic of influenza. It is unproven whether the disease escaped through the tight cordon of the Federal Quarantine. For a long time it was obvious that the disease which had proved so destructive in South Africa and New Zealand, was being held in check by the control of incoming ships. Eventually a fatal form of influenza, frequently complicated by pulmonary involvement, appeared in New South Wales and Victoria. Fortunately, the incidence and the mortality of the disease were lower than they had been in New Zealand and South Africa. Various measures were adopted in different parts of the Commonwealth in the endeavour to stem the spread of the epidemic. It soon became evident that some of the measures were useless, while the efficacy of others has been widely questioned. The epidemic followed a course of typical duration and in some situations the outbreaks recurred. Much clinical experience was gained and many articles have appeared on the clinical manifestations of the disease. Some practitioners have claimed success for particular forms of treatment. Unfortunately, no one has been able to demonstrate the cause of the primary infection. Dr. A. H. Tebbutt has recently published the results of his investigations of the types of pneumococci met with in the pulmonary complications of the disease. This work has not been accomplished before in Australia and is of considerable importance. His observations are in strange agreement with those of Lister in South Africa.

The highly important work of tracing and stamping out anchylostomiasis in Queensland begun by Dr. J. H. Waite, of the International Health Board of the Rockefeller Foundation, has been continued by Dr. W. A. Sawyer, with the assistance of Dr. S. M. Lambert and Dr. G. P. Paul. They have recently been joined by three Australian practitioners, all returned men, Dr. H. Hastings Willis, Dr. C. P. Rosenthal and Dr. L. W. Nott. A fourth medical officer will be appointed in a short time.

The Victorian Parliament has been engaged in considering a comprehensive measure to amend the existing *Health Act*. The new measure, which was passed by both Houses on December 23, 1919, is a distinct improvement on the old one, but is by no means ideal. Its provisions will be described as soon as the Bill is placed on the statute book.

Medical Education.

Changes and rumours of changes in the medical schools of our Universities have marked the year 1919 as one of historical importance. Stimulated by a discussion and report of striking importance by the Edinburgh Pathological Club, the medical faculties have approached the subject of a reform in the medical curriculum with an open mind and an obvious determination to lift the training of the Australian medical student to a level at least as high as that of any other country. Those in authority are at the parting of the ways. The choice has to be made between a radical re-casting and a temporary adjustment. There appear to be few who still adhere to the unprofitable and doubtfully adequate plan of modification of the existing state of affairs. Within a very short time a comprehensive scheme will be placed before the faculties. It is the ardent hope of the majority of reformers in medical education that the ultra-conservatism of the few will give way to the more radical proposals embodied in the scheme.

A preliminary to the changes has already taken place in the University of Sydney. A Chair of Medicine has been created and the first Professor of Medicine is a graduate of this great University, a man whose learning and popularity fits him peculiarly for the office. It is an open secret that a chair of surgery will be established shortly at the University of Sydney.

In the University of Melbourne the only change of importance that has taken place in the year 1919 is the appointment of Dr. W. J. Young, formerly of the Australian Institute of Tropical Medicine, to the position of Lecturer in Bio-Chemistry. This office has remained vacant since the untimely death of Dr. A. C. H. Rothera.

In the University of Adelaide many important changes have occurred. The death of Professor Sir Edward Charles Stirling on March 20, 1919, within a few months of his announced retirement, was a great loss to the University. The University has further been robbed by retirement of a most distinguished and able teacher, Professor A. Watson. The positions of Professor of Physiology and of Professor of Anatomy have been filled by eminent men. They will need to live up to their reputations in order to satisfy the requirements of their offices, as their renowned predecessors did. For some years we have urged the institution of a chair of pathology at the University. It is gratifying to learn that this development has been realized and that the first Professor of Pathology at Adelaide has been appointed recently. Dr. J. Burton Cleland, at present the Principal Micro-Biologist in the Department of Public Health of New South Wales, has been selected for the position and will take up his teaching duties in February, with the assurance that his colleagues in Sydney, no less than his colleagues in Adelaide and his students, wish him equal success in his new sphere of activity as has attended him in the realms of public health work. The school must be adjusted rapidly to modern requirements, but we have no misgivings concerning its future.

In the last place, Brisbane is to have a medical school in its University. The infant has not yet emerged from its embryonic home. All arrangements have been made for the birth of this promising and necessary child of the north. For long we have watched for signs of viability. The generosity of the late Sir Samuel McCaughey has been most timely in rendering the realization of this desideratum possible. We wish the medical school of the University of Brisbane a prosperous and honourable career.

Abstracts from Current Medical Literature.

THERAPEUTICS.

(1) Stability of Salicylates.

P. J. Hanzlik and N. C. Wetzel (*Journ. Pharm. and Exper. Therapeutics*, September, 1919) have studied the conditions of stability and of destruction of the salicyl group under various biological circumstances. It has been observed many times that solutions of sodium salicylate and of other salicyl derivatives lose in strength upon standing for some weeks. This is not generally known and many hold that the salicyl group is not changed even by its passage through the animal organism. Hanzlik has shown previously that it is not possible to account in the excretions for one third of the dose of sodium salicylate administered. The authors bring forward evidence of the case with which the salicyl group is decomposed under ordinary conditions and they suggest that the salicyl which remains unaccounted for in experiments upon man and animals, has been destroyed within the animal body. Their investigations have been made with sodium salicylate, aceto-salicylic acid, salicyl-salicylic acid known as diplosal and with methylene citricyl salicylic acid called usually novaspirin. A preliminary series of experiments have been carried out with solutions in alcohol and in water which have been kept in stoppered bottles. A solution of sodium salicylate in water containing 0.012% has lost 20% of its salicyl groups in 68 days and increasing amounts later, up to 54% in 272 days. A 1% solution in water has lost 21% in 120 days. Aceto-salicylic acid, 1% in alcohol, has lost 5% in 120 days, salicylic acid, 1% in alcohol, has lost 11% in the same time; but novaspirin has showed no loss in strength in the same period. The addition of chloroform to aqueous solutions prevents any diminution in the strength of the liquids. With the object of elucidating these changes, solutions of sodium salicylate in water have been treated in different ways with yeast. Some mixtures have been incubated at body temperature, others have been kept at the temperature of the laboratory. It has been observed that the solutions show less change when yeast is present than when it is absent. Sodium salicylate has been added to mashes made from various organs of a dog. Some of the mixtures have been exposed to the air, while others have been protected by a layer of liquid paraffin on the surface. The loss of salicyl in 72 hours varied from 37.5 to 60% with muscle, liver, brain, pancreas, intestine and blood. No special difference in the behaviour of any organ could be noticed. Some investigations have been completed which show that the salicyl is not combined chemically with the tissues nor is it absorbed. A number of studies have been made on normal persons and on other persons suffering from various diseases. The healthy persons have excreted about 80% of the total dose administered. In persons suffering from fever, either of rheumatic or of tuberculous origin, a further loss of 20% of the dose of salicylate is observed. This loss is ascribed by the authors to the increased metabolism of the fever. The destruction is considered to take place throughout the tissues and not in any particular organ. In nephritis the excretion of salicylates is lessened, so that approximately one half of the dose administered appears in the urine. Two persons addicted to the consumption of excessive amounts of alcohol and one habituated to morphine excreted less salicyl than healthy persons. In Basedow's disease less salicyl is excreted than in normal persons and the diminished excretion is most marked in the acute stages. In three patients with hepatic trouble, the excretion has been similar to that of normal subjects. Some experiments on animals, such as dogs and cats, show that a larger amount of destruction occurs within the bodies of these animals than in man. One half of the salicyl appears to be oxidized within the organism. The authors are of opinion that these facts help to explain the failure of salicylates in small doses to act as effective antiseptics in the blood and in the tissues; the necessity for using large doses for therapeutic effects and the absence of ill-effects when salicylates are employed in low concentrations for the preservation of different kinds of foods.

(2) Effect of Inhalation of Chlorine.

H. G. Barbour (*Journ. Pharm. and Exper. Therapeutics*, September, 1919) has made some observations upon the effects of the inhalation of chlorine by dogs. In collaboration with A. M. Hjort and F. A. Taylor he examined the influence of morphine upon the fatality of poisoning by chlorine. Forty-eight dogs were exposed to air containing 8 parts of chlorine in 10,000. Thirty-five were treated with morphine, while eleven others served as controls. The author applies the term "recovery" to animals which live 72 hours, thus surviving the maximal duration of the acute stage of poisoning with chlorine. Subcutaneous injections of morphine in doses up to 10 mg. per kilo. body weight have, if anything, an unfavourable influence on the poisoned dogs. Small doses exert no more favourable action. The author has tested the use of arculatory stimulants, such as epinephrine, strophanthin and ouabain. He was unable to satisfy himself that these drugs exert a favourable influence on the effects of poisoning by inhaling poison. The author has also made some observations on the effects of inhaling chlorine upon the temperature of dogs. Low concentrations, such as 24 to 30 parts per million, medium concentrations, 180 to 200 parts per million, and high concentrations, such as 900 parts per million, have been used in these experiments. The temperature of the dogs rises about 1° C. as a result of 30 minutes' exposure to the low concentration of chlorine. Medium concentrations lower the temperature about 1° C., while high concentrations lower the temperature the same amount but more persistently. With the medium and high concentrations the pulse is greatly diminished in rate. With the high concentration the pulse rate starts to increase in a few hours and collapse ensues. The author shows that the thermal effects are not due to variations in the rate of the respiration or of the heart. With long haired dogs the fall of temperature does not occur, but the temperature continues to rise and the animals die in a state of collapse. Observations show that the animals become unable to regulate against hot or cold surroundings. The use of the warm box led to overheating of the animals unless they could give off heat at a sufficiently fast rate. Many experiments were made to discover an optimal temperature between 28° C. and 41° C., but the experiments did not yield uniform results. The author attributes these effects to the irritation of the peripheral nerves and the influence of the nervous impulses thereby generated upon the nervous mechanism regulating the temperature of the body.

(3) Action of Strychnine on Suprarenal Capsules.

G. N. Stewart and J. M. Rogoff discuss the action of drugs in augmenting the secretion of epinephrine into the blood, with special reference to the effect of strychnine (*Journ. Pharm. and Exper. Therapeutics*, May, 1919). Previous statements in the literature upon the influence of drugs and other substances on the liberation of adrenalin appear to be based upon experiments by inadequate methods. Some writers interpret changes in the store of epinephrine in terms of rate of output of epinephrine in samples of blood drawn from the suprarenal veins without any reference to the rate of blood flow through the adrenal glands. The authors lay stress on the necessity of measuring the rate of flow through the adrenal glands while the samples of blood are collected in which the epinephrine is assayed by the use of segments of the intestine or uterus of rabbits. In the dog and cat strychnine increases the secretion of epinephrine. The increased secretion is not transient, but persists for some hours. It may amount to ten times the usual quantity. Doses of strychnine, well within the therapeutic range, which cause little or no exaggeration of reflex action, augment the liberation of epinephrine. The concentration in the blood leaving the suprarenal glands is increased, but no evidence could be found showing that the concentration in the plasma as a whole could be increased above the normal maximal limit. The amount of epinephrine, stored in the glands, did not appear to be diminished after the action of strychnine in large and repeated doses. It would thus seem that strychnine accelerates the accumulation of strychnine in the suprarenal glands.

(4) Action of Methyl Salicylate.

P. J. Hanzlik and N. C. Wetzel have made some observations on the excretion of methyl salicylate (*Journ. Pharm.*,

and Exper. Therapeutics, September, 1919). They find that the excretion of the salicyl group in the dog and cat is much less after the administration of methyl salicylate than after the exhibition of sodium salicylate. About one fourth of the dose given to the dog or cat appears in the urine. A small quantity of the free ester appears in the urine after gastric administration, but as much as 15% of the dose appears as methyl salicylate in the urine after intramuscular injections. The authors consider that these results will assist in explaining the greater analgesic action of the ester and the enhanced toxicity of this body. They also believe that these facts account for the value of methyl salicylate as a urinary and systemic antiseptic.

UROLOGY.

(5) The Differential Diagnosis Between Stricture and Calculus of the Ureter.

In 1915 Guy L. Hunner claimed that ureteral stricture was an extremely common affection. He recorded fifty cases at that time. He claimed that the relatively small number was due to the fact that he had not searched systematically for these cases. His statement was not accepted. He now comes forward with a series of 500 cases collected during the intervening period (*New York State Journ. Med.*, September, 1919). The diagnosis is based on the effect of the passage of a wax-tipped ureteral sound. A special wax bulb is used, which is said to hang when passing through the strictured portion of the ureter. Hunner claims that ureteral stricture is the most common cause of pathological affections of the kidney other than nephritis. The differential diagnosis between stricture and calculus of the ureter is arrived at after a full consideration of all the signs and symptoms. It is, as a rule, impossible to make a diagnosis from the history alone. Renal colic, pain radiating down the ureteral line, frequency of micturition, nausea and vomiting and other symptoms associated with ureteral calculus are common in ureteral stricture. Physical examination may reveal a sensitive kidney in both conditions. The urine may contain no abnormal constituents and the practitioner may be inclined to regard the condition as a neurasthenic one. Very careful search should be made, however, for an occasional red blood cell or leucocyte, which would indicate a lesion somewhere in the urinary tract. Radiology may be of considerable use, especially when a stone can be demonstrated in the skiagram. A negative result, however, has no significance at all. Similarly, the cystoscope may reveal the nature of the condition, while in other cases nothing abnormal may be seen. In the absence of definite information from these sources of examination, a wax-tipped catheter should be passed along the ureter. The wax bulb should be carefully examined after withdrawal, for the presence of any scratch marks due to a stone. The shadowgraph catheter may also yield important information on which a diagnosis can be based. Hunner at times makes a spiral wax tip and places small wax rings at every fifth centimetre on the portion of the catheter that will enter the ureter. The situation of the stone or stricture can be localized in this way.

(6) Stricture of the Ureter.

Martin Molony deals with the subject of strictures and obstructions of the ureter, illustrating several of the types by a record of typical cases and discussing the methods employed in the endeavour to re-establish the patency of the tube (*Urol. and Cutan. Review*, October, 1919). According to Hunner, acquired inflammatory strictures of the ureter are extremely frequent. The author shows that this condition can be recognized in the primary stage of contraction and hypertrophy. Dilatation of the renal pelvis and of the proximal portion of the ureter follows at a later date. According to Geraghty and Frontz, anomalous blood vessels of the kidney, movable kidneys, kinks and abnormal insertions of the ureter do not cause hydronephrosis, but are caused by it. The author is able to substantiate these views by the record of a case and by skiagrams. On the other hand, Molony differs from Geraghty in his assertion that inflammatory constrictions of the ureteropelvic junction are a frequent cause of hydro-nephrosis and cannot be permanently overcome by mechanical dilatation. His experience teaches him that infection and inflammation in the ureter are usually secondary to the effects of mechanical obstruction. The obstruction is more commonly a calculus, but may be a fragment of bone compressing the ureter from without. When the obstruction is removed at an early stage, the mild infection existing usually disappears. At a later date the infection leads to a stricture, which can be demonstrated by pyelography. He does not hesitate to dilate these strictures with sounds corresponding to size No. 22 French. The existence of an acute peri-ureteritis is a contra-indication to mechanical dilatation. In many cases the hydronephrosis resulting from the obstruction in the ureter disappears after the removal of the obstruction and good drainage. He claims that the technique is easily learned and that the procedure is devoid of danger. It yields better results than plastic operations and is preferable to nephrectomy.

(7) Syphilis of the Testis.

S. W. Schapira and J. Wittenberg (*Urolog. and Cutan. Review*, June, 1919) call attention to the fact that the testes may be involved in a syphilitic process without any very definite signs and symptoms suggesting it. They recognize a diffuse infiltrating form of syphilis of the testis itself and a gummatous form. In the former the organ is as hard as wood and is atrophic. The entire organ or a part of it may be affected. Testicular sensation is often lost. In the gummatous form there may be one or more gumma, varying in size from that of peanut to that of chestnut. The gumma on cross section is seen to possess a caseating centre, encapsuled by fibrous tissue. It may soften and discharge through the skin, leaving a deep ulcer with a greyish-white base. As a rule gummata do not break through the skin. Associated with these two forms there is usually hydrocele. The gummatous process may involve the *tunica albuginea*. In the next place the epididymis may be involved. The tissues undergo interstitial fibrosis. The process usually begins in the *globus major*, which becomes hard and has a sharp edge, feeling like a metal helmet fitting on the testis. The affection is either unilateral or bilateral, while syphilis of the testis proper is usually unilateral. The authors have had occasion to treat a number of soldiers from southern American States in whom the disease was of a much more destructive nature than it was in the inhabitants of New York. They do not offer any explanation for this difference. The symptoms are usually limited to a feeling of dragging weight in the testis extending to the groin. The sexual appetite and power may be lost when both organs are involved. The lesions clear up rapidly under appropriate anti-syphilitic treatment. At times it is necessary to deal with the hydrocele by open operation.

(8) Extravasation of Urine Without Stricture.

H. McClure Young (*Urolog. and Cutan. Review*, May, 1919) relates the history of a patient admitted to the No. 1 British Stationary Hospital at Rouen with the classical signs and symptoms of urinary extravasation. He had gone to bed on the previous night in perfect health and on awakening in the morning found himself in the condition described below. The scrotum was greatly swollen and necrosis was commencing at the lowest point. The horny layer of epithelium was broken and fluid was oozing through. There was œdema extending along both inguinal regions and in the perineum. The urine was free from blood. The patient was able to pass a good stream of urine. He denied having suffered from stricture. He stated that he had not been drinking and that he had not suffered any injury. Multiple incisions were made in the skin of the scrotum and of the groins. A No. 24 sound was passed without obstruction into the bladder and no signs of stricture was felt. The deep urethra was opened upon the sound and a large catheter was passed and allowed to remain *in situ*. The patient made an uninterrupted recovery. Young points out that the signs of extravasation are not produced in the manner suggested. A few drops of urine may give rise to a reaction and the œdema and extravasated fluid are due not to urine but to inflammatory exudation. It is usually held that the condition follows a stricture. A small ulcer usually forms behind the stricture and through this ulcer the drops of urine pass into the tissues. Complete retention is neither necessary nor the rule. He regards the occurrence of extravasation without stricture as extremely uncommon.

British Medical Association News.

ANNUAL MEETING.

The annual meeting of the Queensland Branch was held at the B.M.A. Rooms, Adelaide Street, Brisbane, on December 5, 1919, Dr. A. Sutton, the President, in the chair.

Annual Report.

The Honorary Secretary presented the annual report of the Council and suggested that it be taken as read.

Dr. W. F. Taylor, in moving the adoption of the report, congratulated the Branch on its sound position and on the amount of work carried out during the year. Dr. F. Howson seconded the motion, which was carried unanimously.

Annual Report of Council, 1919.

The Council has the honour to present the following report of the work of the Branch for the year ended November 30, 1919.

Membership.

The Branch has now a membership of 281. During the year ten new members were elected, seventeen transferred from other Branches, fifteen transferred to other Branches, two resigned, one struck off (unfinancial) and eight died.

The Council regrets to record the following losses by death: Dr. H. D. Welply, Dr. R. J. Driscoll, Dr. E. MacLeod Smith, Dr. John Flynn, Dr. A. E. Mackenzie, Dr. W. E. Macfarlane, Major H. H. Griffith and Captain H. South. The two last named died whilst on military service.

A hearty welcome home is extended to the following members, who have returned from active service during the year: Dr. T. O. Chenoweth, Dr. W. R. Kelly, Dr. L. B. Elwell, Dr. J. S. Streeter, Dr. A. M. McIntosh, Dr. J. King Patrick, Dr. A. B. Steele, Dr. W. D. Quilty, M.C., Dr. E. G. Thomson. Dr. A. J. Reye, Dr. E. D. Ahern, Dr. A. W, T, Nisbet, Dr. J. J. Power, D.S.O., Dr. A. H. Marks, C.B.E., D.S.O., Dr. L. W. Millett, Dr. J. Ross, Dr. C. J. Weedon, Dr. J. Hardie, M.C., Dr. D. G. Croll, C.B.E., Dr. R. Marshall Allan, M.C., Dr. C. H. Clatworthy, Dr. J. J. V. Duhig, Dr. G. H. Cameron, Dr. A. McKillop, Dr. E. S. Meyers, Dr. J. S. Smyth, Dr. F. C. Wooster, D.S.O..

The town membership (which includes members living within a radius of 25 miles of Brisbane) has increased considerably within the last year, there being now 116 town members, as against 96 in 1918.

Meetings.

The annual meeting was held on December 6, 1918, at which the retiring President made some remarks on the year's progress, etc., the result of the election of officers for 1919 was announced and the Council's report and Honorary Treasurer's statement were adopted.

General Meetings.—Owing to the influenza epidemic, no general meetings were held from May 2 to September 5. Thus, only eight ordinary monthly meetings were held and four special meetings, the average attendance being 26. As usual, no meeting was held in January. The special meetings were called for the following purposes: (1) To hear an address by Dr. E. J. Stuckey, B.Sc., O.B.E., Principal of the Union Medical College, Peking, who was passing through Brisbane. (2) To discuss several motions and other business which had accumulated owing to the discontinuance of the general meetings during the influenza epidemic. (3 and 4) To consider the proposed scheme for the appointment of the medical staff at the Brisbane Hospital.

Council Meetings.—The Council held twenty-two ordinary and six special meetings, four of the latter being devoted to business in connexion with the influenza epidemic. The attendance of members of the Council at the various meetings was as follows:—

Dr. A. Sutton (President)	23
Dr. A. Stewart (Vice-President)	26
Dr. J. Espie Dods (Vice-President)	21
Dr. J. C. Hemsley (Honorary Secretary)	24
Dr. E. J. Spark (Honorary Treasurer)	11
Dr. T. H. R. Mathewson (Honorary Librarian)	21
Dr. F. Howson (Honorary Curator of Museum)	19
Dr. Eustace Russell	21
Dr. L. M. McKillop	22
Dr. C. A. Thelander	17
Dr. L. P. Winterbotham	16

It was the intention of the Council to arrange for a visitor from one of the southern Branches to read a paper before the August meeting, but owing to the prevalence of the influenza epidemic in the south, as well as here, the idea had to be abandoned.

The following is a list of papers which were read before the Branch during the year:—

February 7.—Dr. A. J. Turner: "Medical Gleanings from the War." Dr. D. A. Cameron: "Surgical Fragments."

March 7.—Dr. C. S. Hawkes: "Some Aspects of Orthopædic Work." Dr. J. L. Gibson: "The Importance of De-ionization in the Treatment of Plumbism in Children."

April 4.—Dr. Eustace Russell: "The Diagnosis of Pulmonary Tuberculosis."

May 2.—Discussion on influenza epidemic.

July 26.—Dr. E. J. Stuckey (Peking): "Medical Work Amongst the Chinese."

September 5.—Dr. E. Kent Hughes: "Observations on Congenital Syphilis at the Brisbane Children's Hospital." Dr. L. M. McKillop: "The Early Diagnosis of Cancer of the Alimentary Canal."

October 3.—Dr. R. A. Macleod (Gympie): "Intestinal Obstruction."

November 7.—Dr. A. S. Roe: "The Value of the Cystoscope as a Means of Diagnosis in Urology." Dr. A. W. Dean: "The Isolation of Organisms Resembling the Paratyphoid Group."

Many interesting cases and specimens were exhibited at the various meetings. We are indebted to the following sub-committee for the arrangement of the programme of papers for the year: Drs. T. H. R. Mathewson, F. Howson, Eustace Russell and L. M. McKillop.

Federal Committee.

Owing to the influenza epidemic, only one Federal Committee meeting was held this year, at which the Branch was represented by Dr. J. L. Gibson and Dr. J. Espie Dods (who was appointed in place of Dr. W. N. Robertson, who was unable to attend, owing to ill-health).

Dr. J. L. Gibson and Dr. W. N. Robertson have been appointed delegates for the ensuing year. A report of the proceedings of the meeting was published in *The Medical Journal of Australia* under dates August 9 and 16, 1919.

Friendly Societies and Lodges: Model Lodge Agreement.

At a special meeting of the Branch held on August 22, a motion passed at a general meeting held on August 7, 1914, *viz.*:—

> In view of the commercial depression resulting from the war and the need for mutual self-help, that the introduction of the new agreement between medical men and their lodges be deferred for the present.

was reconsidered, with the result that it was unanimously carried that the above resolution should be rescinded and that the model lodge agreement, as it stood at the outbreak of war, should be carried out in its entirety. The Associated Friendly Societies were duly notified and it was mentioned that the new ruling should date from October 1, 1919. This means that the financial clauses, which were decided on in 1914 and left in abeyance owing to the war, are now operative in regard to the metropolitan area; no arrangements have been made for country districts so far.

Hospitals.

The Hospital Sub-Committee has been unable to reach any finality with regard to drawing up rules in connexion with country hospitals, owing to the fact that conditions vary considerably in each town, but the matter is still receiving attention and a great deal of the Council's time has been occupied with matters pertaining to hospitals.

Suggested Scheme for the Appointment of the Medical Staff at the Brisbane General Hospital.—A resolution was passed by the Branch to the effect that it should be pointed out to the Government that the Branch considers the present method of making appointments to the medical staff of the Brisbane Hospital is unsatisfactory and in the interests of the public urgently demands alteration. Also that it be represented to the Government the desirability of all such appointments being made on the recommendation of an advisory board. It was resolved that the Council should formulate a scheme to be submitted to the Government after

having been first approved of by the members. A scheme was therefore drawn up by the Council and submitted to the members at a special meeting held on September 19, 1919, when it was amended and approved of and subsequently presented to the Home Secretary by a deputation consisting of the President and Honorary Secretary.

Medical Officers' Relief Fund (Federal).

Up to date, the total sum received by this Branch, in both donations and promises, amounts to £1,501 18s. 4d., which has been contributed by about fifty subscribers and it is hoped that each member who is in a position to do so, will contribute to this fund.

Australasian Medical Congress.

Arrangements are now being made in connexion with the Eleventh Session of the Australasian Medical Congress, which is to be held in Brisbane during August of next year (1920). It is earnestly desired that the Congress will receive the unanimous support of the medical profession in Queensland and that every effort will be made by the members of this Branch to make it an unqualified success, an assurance having been given by the Branch to the Executive Committee of Congress to that effect.

General.

Influenza Epidemic.—During the influenza epidemic in Brisbane, the Council was appointed to act as an advisory committee to the Government and gave up a great deal of its time in this connexion.

University of Queensland.—At the request of the University Social Workers' League, the President was appointed to represent the Branch on the Advisory Council in connexion with a movement with regard to "Justice for our Aborigines."

Sir David Hardie, M.D., and Dr. A. J. Turner were appointed delegates to attend a conference of the Select Committee of the Council of the University and the nominees of societies, organizations and associations with reference to widening the scope of the Council of the University.

New Site.—As the result of a motion passed by the Branch, dealing with the new site for the University, a recommendation was sent to the University Senate, pointing out the advantages of the Victoria Park site.

Poisons Regulations (1918).—With a view to entering a protest against certain of these regulations, which were considered cumbersome and unnecessary, a conference of interested bodies, *viz.*, the Medical Board, the Queensland Branch of the British Medical Association, the Pharmacy Board and the Pharmaceutical Society, was held, at which the Branch was represented by the President and Dr. A. Stewart. A deputation subsequently waited on the Health Commissioner in this connexion, the President, Drs. A. Stewart and Eustace Russell being appointed as representatives of the Branch.

Queensland Medical Land Investment Company, Limited, Shares.—A further 25 shares in this company were purchased during the year, making a total of 525 shares now held by the Branch.

Library.

We are indebted to Dr. A. J. Turner for a number of valuable medical books, which he kindly presented to the Library. Dr. H. T. S. Bell has also kindly presented us with a set of "An Atlas of Illustrations of Clinical Medicine, Surgery and Pathology," compiled by the Sydenham Society.

The following members have kindly promised to supply the undermentioned journals to the Library:—

Dr. Eustace Russell: *The Practitioner.*
Dr. C. A. Thelander: *Annals of Surgery.*
Dr. A. Sutton: *Journal of the Royal Army Medical Corps.*
Dr. F. Howson: *Brain.*

The following is a list of journals now subscribed to by the Branch, apart from those being presented by members, as mentioned above:—

British Medical Journal.
The Medical Journal of Australia.
Lancet.
British Journal of Surgery.
The Quarterly Journal of Medicine.
Endocrinology.
The American Journal of the Medical Sciences.
The Journal of the American Medical Association.
The Journal of Tropical Medicine and Hygiene.
Progressive Medicine.
Edinburgh Medical Journal (to commence at the beginning of next year).
The Review of Neurology and Psychiatry (to commence at the beginning of next year).

J. CAMERON HEMSLEY,
Honorary Secretary.

Financial Statement.

In the absence of Drs. E. J. S. Spark, the Honorary Treasurer, Dr. J. C. Hemsley, the Honorary Secretary, presented the balance sheet and the profit and loss account. He also presented a balance sheet prepared by the local committee for Queensland of the Medical Officers' Relief Fund.

Dr. J. Espie Dods moved the adoption of the financial statement and Dr. A. B. Brockway seconded the proposal, which was carried.

Presidential Address.

Dr. A. Sutton, the retiring President, delivered his address (see page 1).

Sir David Hardie moved a hearty vote of thanks to Dr. Sutton for his admirable address. The motion was carried by acclamation. Dr. Sutton replied in suitable terms.

Induction of President.

The retiring President, on vacating the chair, introduced his successor, Sir David Hardie.

Sir David Hardie thanked the members for the great honour they had conferred upon him, in electing him President of the Branch. He moved a hearty vote of thanks to Dr. J. Cameron Hemsley, who had acted as Honorary Secretary during the past four years. The motion was carried by acclamation. Dr. Hemsley replied.

Queensland Medical Land Investment Company.

Dr. W. N. Robertson, speaking as the Managing Director of the Queensland Medical Land Investment Company, said that the directors thought that the time had arrived when those members who had joined the Branch since the company had been floated, should be asked to take up some of the unissued shares. If this were done, the mortgage could be reduced. He mentioned that £800 had already been paid off.

Dr. W. N. Robertson moved and Dr. E. D. Ahern seconded, that it be an instruction to the incoming Council that future copies of the balance sheet be distributed before the annual meeting. The motion was carried.

Dr. A. B. Brockway moved and Dr. R. G. Brown seconded, that it be an instruction to the incoming Council to consider the advisability of transferring the account in the Bank of Queensland to the Government Savings Bank. The motion was carried.

Election of Office-Bearers.

The following were appointed office-bearers and members of the Council:—

President: Sir David Hardie, K.B..
Vice-Presidents: Colonel A. Graham Butler, D.S.O., and Dr. A. Sutton, C.B., C.M.G., V.D..
Honorary Secretary: Dr. R. Marshall Allan, M.C..
Honorary Treasurer: Dr. D. Gifford Croll, C.B.E..
Honorary Librarian: Dr. Donald A. Cameron.
Honorary Curator of Museum: Dr. E. D. Ahern.
Members of Council: Dr. J. Espie Dods, D.S.O., M.C., Dr. Alex. Marks, C.B.E., D.S.O., Dr. G. P. Dixon, C.B.E., and Dr. W. N. Robertson.

War Specimens.

Dr. W. N. Robertson referred to the fact that a number of war specimens collected by the Australian War Records Section had been brought over to Australia. Some of these specimens had been allotted to their University. They were at present under the charge of Dr. Dean, at the Microbiological Laboratory, and could be viewed there by the members.

Election of Honorary Treasurer.

Dr. L. M. McKillop asked if a nomination for the office of Honorary Treasurer could be submitted. He pointed out that no one had been willing to be nominated to this posi-

tion. He begged leave to nominate Dr. R. Graham Brown. The nomination was seconded by Dr. J. P. Kerwin.

Dr. E. D. Ahern nominated Dr. D. Gifford Croll and Dr. Lockhart Gibson seconded the nomination.

Dr. W. N. Robertson held that the Treasurer should be elected by the Council, while Dr. W. F. Taylor expressed the view that the Treasurer should be elected by the members of the Branch. Dr. A. Sutton, quoting the rules of the Branch, maintained that Dr. Robertson's contention was correct. The President ruled that the wording of the rule was not explicit and that the Treasurer should be elected by the meeting. A ballot was taken and Dr. Croll was elected.

Balance Sheet as at November 24, 1919.

Liabilities.	£ s. d.	£ s. d.	*Assets.*	£ s. d.	£ s. d.
Accumulation Fund—			Library	150 0 0	
Balance, November 26, 1918	702 18 2		Book Cases	47 0 0	
Transfer from Revenue Account, November 24, 1919	37 1 11		Furniture and Fittings	48 10 0	
		740 0 1	Queensland Medical Land Investment Company, Limited: 525 Shares Paid to 10s. per Share	262 10 0	
British Medical Association, London: Members' Subscriptions Collected but not Remitted by Branch at Close of Financial Year	15 4 6		Museum Specimens	5 0 0	
Australian Medical Publishing Company, Limited: Balance due at November 24, 1919	81 0 0		Credit Balance, Bank of Queensland, Limited, Brisbane	194 18 0	
Subscriptions Paid in Advance on account of Year 1920	1 5 3		Credit Balance, Queensland Government Savings Bank, Brisbane	127 4 7	
		97 9 9	Cash in Hand	2 7 3	
					837 9 10
Harold Plant Memorial Fund		209 2 5	Harold Plant Memorial Fund—		
			Commonwealth 4½% War Loan, £200	198 0 0	
			Credit Balance, Queensland Government Savings Bank	11 2 5	
					209 2 5
		£1,046 12 3			£1,046 12 3

Brisbane, November 29, 1919.

E. J. S. SPARK,
Honorary Treasurer.

Audited and found correct,
ROY G. GROOM, F.C.P.A., F.I.A.Q.,
Auditor.

Statement of Receipts and Payments for Twelve Months Ended November 24, 1919.

Receipts.	£ s. d.	£ s. d.	*Payments.*	£ s. d.	£ s. d.
November 27, 1918—			November 24, 1919—		
To Credit Balance, Bank of Queensland, Limited, Brisbane	116 16 3		By British Medical Association, London: Remittances on Account of Subscriptions, including Subscriptions of Members on Active Service		259 17 0
„ Credit Balance, Queensland Government Savings Bank, Brisbane	122 19 2		„ Australian Medical Publishing Company, Limited: Remittances on Account of Subscription to *The Medical Journal of Australia*		233 0 0
„ Cash in Hand	3 14 6		„ Queensland Medical Land Investment Company, Limited: Purchase of 25 Shares		12 10 0
		243 9 11	„ Library Expenditure: Books, Journals and Bookbinding		17 3 0
November 24, 1919—			„ Branch Expenses—		
To Subscriptions—			Secretary: Salary	£113 19 4	
British Medical Association, London	242 11 0		Printing and Stationery	16 18 3	
The Medical Journal of Australia	233 0 0		Electric Light	11 12 0	
Queensland Branch Subscriptions	114 16 6		Bank Charges	1 19 9	
Organization Fund	224 10 9		Postages and Duty Stamps	19 14 4	
On account Subscriptions, 1920	1 5 3		Rent	12 0 0	
		816 3 6	Cleaning	12 10 0	
„ Dividends and Interest—			Night Watchman	3 10 9	
Queensland Medical Land Investment Company, Limited: Dividend on 500 Shares	12 10 0		Telephone	11 9 10	
Queensland Government Savings Bank Interest	4 5 5		Legal Expenses	1 1 0	
		16 15 5	Insurance: Furniture and Library	1 4 0	
„ Australian Medical Publishing Company, Limited: Rebate on Account of Subscriptions to *The Medical Journal of Australia*		23 4 0	Audit Fee	6 6 0	
„ Harold Plant Memorial Fund—			Expenses *re* Federal Committee	22 13 0	
Credit Balance, Queensland Government Savings Bank, Brisbane, November 27, 1918	2 0 0		General Expenses	17 13 10	
Federal War Loan Interest	9 0 0				252 12 1
Queensland Government Savings Bank Interest	0 2 5		„ Harold Plant Memorial Fund: Credit Balance, Queensland Government Savings Bank, Brisbane		11 2 5
		11 2 5	„ Credit Balance, Bank of Queensland, Limited, Brisbane	£194 18 0	
			„ Credit Balance, Queensland Government Savings Bank, Brisbane	127 4 7	
			„ Cash in Hand	2 7 3	
					324 9 10
		£1,110 15 3			£1,110 15 3

SCIENTIFIC.

A meeting of the South Australian Branch was held in the Lister Hall, Hindmarsh Square, Adelaide, on October 30, 1919, Dr. H. S. Newland, the President, in the chair.

Dr. T. G. Wilson read a paper on the results and treatment of yielding of the suspensory apparatus of the female pelvic organs (see page 2).

Dr. A. A. Lendon said that, through the courtesy of Dr. Wilson, he had had an opportunity of perusing his paper beforehand. The merit of the paper seems to him to be in the manner in which he had divided up his subject, as it were, into more or less water-tight compartments. But there were two points to which he would like to allude. The one was the question of pessaries. Whilst admitting that they were not wholly good, he doubted whether they were as bad as they were painted. The bogey of cancer was slight. He had seen it once where a hard vulcanite pessary had been in the vagina for some 18 years unknown to the patient. In many directions their usefulness was beyond question, for example, a Hodge pessary for retroflexion in early pregnancy and a cup and stem pessary for prolapse. Recently he had a startling experience. A lady of 57, much troubled with chronic bronchitis and emphysema, had had ventro-fixation performed by an eminent surgeon twelve years ago. The success was ephemeral. When seen, the cervix was permanently resident outside the vulva. When the finger was introduced into the rectum and a catheter into the bladder, both were felt outside on the cervix. The procidentia was of the size of a large navel orange. The sound went in 12.5 cm.. The operation known as Kocher's, of bringing the *corpus uteri* out of the abdomen and placing it under the skin by suturing it to the rectal fascia was performed. The band resulting from the hysteropexy was tough and had not yielded, but the *corpus uteri* was elongated out like a tongue. The immediate effect of the operation was good and the incontinence of urine, her chief complaint, was cured. In a few months the cervix was outside the vulva again. From a paper in the *Proceedings of the Royal Society of Medicine* (January, 1919) he gathered that, if the perineum were restored and a pessary inserted, the cervix would probably reinvolute. Her condition would not allow of this at the time. He thanked Dr. Wilson for his paper.

Dr. J. A. G. Hamilton congratulated Dr. Wilson on his practical and thoughtful paper. He was unable within the time at his disposal to discuss fully the mechanism of the support of the female pelvic organs. Various theories were held regarding this subject. He thought that they should realize that no one factor was independent of another and that the harmonious action of all determined the result. It was seldom that one factor alone was affected. Every gynæcologist had seen marked retro-flexions in women who presented no symptoms of disease. In view of this, certain writers had denied the pathological importance of retro-displacements completely. If the displacement did not constitute a disease in itself, it certainly created for the displaced organ a marked vulnerability, which resulted from the alteration in the circulation produced by the increased venous congestion and from the nutritive changes which were the consequences of the condition. The displacement also favoured and preserved inflammation of the uterus, both on its surface and in its cavity.

The number of operations for displacement of the uterus were legion. He thought that it was Baldy who had said that they were only limited by the number of women in America. It was evident that no satisfactory solution of the difficulty had yet been reached. In his remarks he would limit himself to the curative measures he had used. They must, however, remember that each case might require a different form of treatment. In determining the treatment of displacement, the age of the woman and whether she was in the child-bearing period of life or whether she had passed the menopause had to be taken into account. Retro-displacements might be divided into two groups. In the first group it affected the young married or single woman who had not borne children. There was no definite enlargement or increase of weight of the uterus due to puerperal or venereal infection. The vaginal outlet was in good condition and the ligamentous supports were not atrophied by long continued stretching. In the second group the patients were women who had borne children. The uterus was sub-involuted and heavy, as a result of previous confinements or infections or because of the passive congestion due to interference with the blood supply of the uterus in a long continued displacement. The vaginal outlet was torn or stretched and the ligaments and other supports were weakened or atrophied by prolonged stretching or disuse. In the first group almost any operation on the round ligaments would give satisfactory results, as the ligaments would quickly recover their elasticity. He said advisedly that the operative support of the uterus should be the round ligament; no other structure had the power of evolution and involution with the uterus. The operation of fixing the uterus of a woman likely to become pregnant to the peritoneum or any other structure which did not possess this power, was likely to be followed not only by failure but by disaster. He had taught for many years that the Alexander-Adams operation was the ideal one for cases of this group. He had, however, found himself using this operation less each year, as he had noted that the majority of cases of retro-displacement were accompanied by some complication, which could only be dealt with through the opened abdomen. The modification of the operation suggested by McKay, in which the complications were dealt with by dilating the internal ring, did not appear to him to be on sound lines. It might be followed by a hernia. He used Baldy's operation or a modification of Vinberg's operation. In the latter a small median incision was made as low as possible, close to the pubes, the bladder was pushed down and a needle armed with a chromic suture was passed through the rectus muscle close to the edge of the incision. The suture was passed round the round ligament, close to the uterine cornu, and back again through the muscle and tied there. This suture would hold the fundus in a forward position until the ligaments recovered their elasticity. In his opinion this was a superior operation to Gilliam's, as it secured the ligament at its strongest part and left no potential space for strangulation of a loop of bowel.

In the second group he had found Baldy's operation gave satisfactory results. He had performed it in over 700 cases and had found the results highly satisfactory. The uterus was supported in a cradle formed by the round and broad ligaments and was further held in place by the pull on the round ligaments from the cornu of the uterus to the internal ring. The intra-abdominal pressure was uniformly on the posterior wall of the uterus. In his opinion this was the only operation on the round ligaments which placed the uterus in its normal position of antiflexion. After Gilliam's operation or any of its modifications the uterus was supported entirely by suspension. If the position of the organ were studied after this operation, it would be noticed that it was suspended in an abnormal position out of the pelvis and more or less vertical. He added that it was scarcely necessary to state that any operative procedure for a retroflexed uterus was incomplete without a plastic operation on the cervix and vagina, when these structures had been torn or lacerated. It would be a good plan, when dealing with a retro-displaced uterus in a case requiring the removal of one or both appendages, to bring the round ligament in a fan-shape and to stitch it over the cornu and back of the uterus. This covered the raw place and at the same time held the uterus up out of the pelvis.

Prolapse of the uterus might be divided into three classes. In the first the patient was a comparatively young woman in the child-bearing period of life. In the second class the patient was a middle-aged woman at or about the menopause and in the third she was an old woman with the uterus protruding through the introitus, with atrophic ligamentous supports and a pelvic floor weakened by continuous stretching and wasting, with atrophy of all her muscular structures. In the first class anterior and posterior colporrhaphy, with repair of the cervix, when necessary, by some operation from above to keep the uterus lifted off the newly repaired pelvic floor, would generally be sufficient. He had found that, although it would cure a retro-displacement, Baldy's operation was not sufficient to keep a prolapsed uterus from sagging down on the pelvic floor. He was accustomed to perform Vinberg's or Richardson's operation. In the latter the round ligament was divided at its centre; the distal portion was fixed to the back of the uterus and the proximal end was brought through the parietal wall and fixed to the back of the sheath of the rectus. He considered that an amputation of the cervix in a woman likely to bear

children was rarely justifiable. In the second class, when there was marked prolapse and elongation of the supra-vaginal cervix and an accompanying prolapse of the bladder and of the anterior wall of the rectum, an amputation of the hypertrophied and elongated cervix was essential, combined with a somewhat exaggerated perineorrhaphy. In considering the best form of operation to keep the uterus up in these cases, he stated that the organ was usually congested and hypertrophied from interference with its blood supply. In some cases a ventro-suspension sufficed. This should be carried out by removing a narrow strip of the peritoneum covering the uterus and cutting out a small piece of the peritoneum from each side of the incision. The raw surface of the uterus was fixed against the parietal fascia by means of through-and-through silk-worm gut sutures. When there was much hypertrophy of the uterus he had found it better to perform a high amputation of the body of the uterus, to fix the round and broad ligaments to the back of the cervix, thus pulling up the vaginal walls, and to fix the cervix with chromic sutures to the fascia of the parietal wall. This operation had given him excellent results. In the third class the uterine ligaments and pelvic attachments had become so stretched and atrophic that they could not again regain any functional usefulness. The normal shape and size of the uterus had become greatly changed from elongation of the supra-vaginal cervix and hypertrophy of the infra-vaginal cervix. The vaginal cervix had become stretched to several times its normal dimensions and the delicate mucous membrane from friction and exposure had become tough and cutaneous in character. The large protruding uterus and inverted vagina stretched the vaginal outlet far beyond its normal size and the muscular supports that had remained after the vaginal perineal injury, underwent atrophy from pressure. In these cases an amputation of the cervix with a repair of the perineum and an amputation of the *fundus uteri*, with a fixation of the cervix to the parietal fascia, would give moderately satisfactory results. But many of the patients were weakly old women or very obese women, who did not stand a prolonged abdominal operation well. He had been accustomed in this class of case to do a vaginal hysterectomy. He agreed with Dr. Wilson when he said that the removal of the uterus was quite inadequate, as the prolapse of the vaginal walls still continued. In fact, the prolapse generally increased as the vagina lost the support of the uterus. This difficulty, however, could be overcome by fixing the cut ends of the broad ligaments together at the roof of the vagina after the uterus had been removed. The surplus portion of the anterior and posterior vaginal walls was then cut away and the raw edges were fixed to the broad ligaments at the top of the vagina. The ligaments soon retracted and pulled up the vaginal walls. The operation produced comparatively little shock in an elderly woman. The perineum could be repaired at the same time or left till a later sitting, if the patient's condition did not justify it. He had had no experience of the operation mentioned by Dr. Wilson, of rendering taut the lateral ligaments or so-called "cardinal ligaments" of the uterus, but when the details of the operation were first published, he had had an opportunity of seeing Professor Watson dissect out these ligaments from above in a *corpus* and had observed that they were definite structures, containing muscular fibres, forming part of the parametrium. He had, however, come to the conclusion that in dissecting them out from above there was danger of wounding large vessels. He could quite understand that if these ligaments were brought together in front of the cervix from below, they would push the cervix back into the hollow of the sacrum and tilt the fundus forward. He could not understand how they would hold up a well-marked prolapsed uterus.

He was quite in accord with Dr. Wilson in his remarks on the use of pessaries. He did not go quite the length of one writer, who had described them as useful toys for parlour games to amuse the children; they had a very limited field of usefulness. They were quite useless and frequently harmful in old-standing retroflexion or prolapse, but they certainly had an important field of usefulness in the retroflexions occurring immediately after a confinement or miscarriage. For some years he had been accustomed to teach the student that in these cases pessaries were not only useful but in many cases curative. They heard much about pre-natal care, but very little about post-natal care. Every conscientious practitioner examined the pregnant woman several times during the later months of pregnancy. How many examined her a few weeks after the confinement? It was at this time, when the uterus was heavy and subinvoluted, with all its supports relaxed and stretched, that retrodisplacements frequently took place. The displacement would become permanent if not attended to at that time. Every woman should be examined a few weeks after delivery and if the uterus was found to be retroflexed, she should be placed in the "knee-chest" position, so that the heavy uterus would fall forward, and a well-fitting pessary inserted and retained for a few weeks. In the majority of the cases this would keep the uterus in its normal position and lead to a permanent cure. It would save operative procedure which would otherwise become inevitable later. He had tried Wertheim's operation by transposition of the uterus in the vagina. It had not appealed to him as a good operation. In one case the patient had had considerable trouble with the bladder after the operation.

The undermentioned have been nominated for election as members of the New South Wales Branch:—

William Stuart Hawthorne, Esq., M.B., Ch.M., 1915 (Univ. Sydney), Liverpool Road, Summer Hill.

Lancelot John Hunter, Esq., M.B., 1915 (Univ. Sydney), c/o. Dr. G. C. Moxham, Powell Street, Killara.

Miss Brenda Aileen Mitchell, M.B., 1919 (Univ. Sydney), Mater Misericordiæ Hospital, North Sydney.

David Thomas Rushton Smith, Esq., M.B., Ch.M., 1919 (Univ. Sydney), 68 Kareela Road, Cremorne.

Alfred Meillon Langan, Esq., M.B., 1915 (Univ. Sydney), 10 Council Street, Waverley.

Bryan Aloysius Veech, Esq., M.B., Ch.M., 1916 (Univ. Sydney), Canowindra.

Joseph Benedict McElhone, Esq., M.B., Ch.M., 1919 (Univ. Sydney), Crick Street, Chatswood.

MEDICAL DEFENCE SOCIETY OF QUEENSLAND.

The annual meeting of the Medical Defence Society of Queensland was held on December 11, 1919, Dr. J. Espie Dods, the President, in the chair. The Honorary Secretary, Dr. J. Cameron Hemsley, read the report of the Council.

Report of Council for 1919.

During the year no legal cases have been dealt with. The Society was approached by a member to refund an amount for a claim brought against him by one of his patients for malpractice, which he had settled himself without consulting the Solicitors of the Society. Under these circumstances, the Council was unable to make him any allowance.

The Council was also asked for the support of the Society by both sides in a case of "defamation," which had been brought against one member by another member of the Society. The Council offered to arbitrate between the parties in the matter, but the case was subsequently settled out of Court.

The Council would like to point out that the Medical Defence Society of Queensland was formed and exists for the purpose of helping, as far as possible, its members to resist unjust or illegal demands. It is not a guarantee society and, therefore, is in no way under any obligation to assist a member who by his own act has rendered himself liable to a penalty; but it may, even under such circumstances, out of sympathy for a member, offer its services to help in mitigating the penalty.

Dr. J. S. Clowes, who had been President of the Society for four years, resigned on account of ill health last year, and Dr. J. Espie Dods was elected to fill this office. Dr. A. Stewart was elected to fill the vacancy on the Council.

The Society has now a membership of 145. During the year 15 new members were elected, 2 resigned, 4 left the State and we regret to record the following losses by death: Dr. H. D. Welply, Dr. A. C. Mackenzie, Dr. E. Macleod Smith, Dr. J. Flynn, Dr. W. E. McFarlane and Dr. Harold South.

A further £100 was invested in the Peace Loan, which was taken out of the current account in the Bank of Queensland, making a total of £600 now invested in Treasury Bonds.

The total assets of the Society now amount ot £956 6s. 11d.

In the absence of Dr. E. J. S. Spark, the Honorary Treasurer, Dr. Hemsley presented the balance sheet and moved its adoption. The motion was seconded by Dr. A. Marks and was carried.

The President reported that Drs. Hemsley and Spark did not seek re-election as members of the Council. Dr. Hemsley had resigned from the honorary secretaryship of the Queensland Branch of the British Medical Association and, as he held that the secretaryship of the Defence Society and that of the Queensland Branch should be filled by one person, he had determined to relinquish the position. Dr. Spark's resignation was due to ill health.

On the motion of Dr. J. C. Hemsley, seconded by Dr. E. D. Ahern, Dr. R. Marshall Allan was elected a member of the Council. On the motion of Dr. E. S. Jackson, seconded by Dr. W. N. Robertson, Dr. A. Marks was elected to fill the second vacancy.

The President moved hearty votes of thanks to Dr. Hemsley and Dr. Spark for their past services to the Society. The votes were carried by acclamation. It was resolved to send a letter sympathizing with Dr. Spark on account of his illness.

It was moved by Dr. W. N. Robertson, seconded by Dr. J. Lockhart Gibson and resolved, that Mr. R. G. Groom be asked to accept the position of auditor for the ensuing year at a fee of £2 2s.

The President drew the attention of the meeting to the question of whether the Society should take out an indemnity insurance policy. It was reported that the State Government Insurance Office had under consideration this class of insurance. It was resolved to refer the matter to the Council with power to act.

Dr. G. Ewing Thomson, of Bundaberg, and Dr. D. F. Finlay, of Texas, were elected members.

THE QUEENSLAND MEDICAL LAND INVESTMENT COMPANY, LIMITED.

The following is the annual report of the Queensland Medical Land Investment Company, Limited.

Report of Directors for 1919.

Your Directors have pleasure in handing you herewith copy of the balance sheet and profit and loss account for the year ended November 25, 1919. The year's operations result in a net profit of £240 19s. 6d., as shown by the profit and loss account.

The year has been an uneventful one as regards the working of the Company, everything running smoothly.

At the last annual meeting a dividend of 5% (free of income tax) on the amount paid up on the shares, was declared and paid during December; this being the fifth dividend of 5% paid by the Company.

During the year a further £100 was paid off the loan from the Diocesan Synod, making a total of £800 since the building was occupied in 1913. Our terms of agreement in connexion with the loan from the Diocesan Synod expired in September, but has been renewed for a further period of three years at the rate of 6½% interest, which is 1½% higher than the previous agreement. However, when taking into consideration existing conditions in the money market, this rate is quite satisfactory.

It is proposed to declare a further divided of 5%, free of income tax, at the annual meeting to be held on Thursday, December 11, 1919.

The following amounts have been paid for rates and taxes during the year:—

	£	s.	d.
Tax on Dividend	7	1	0
Rates	63	8	9
Queensland Land Tax	20	0	0
Queensland Income Tax	4	13	0
Federal Income Tax	18	7	6
	£113	10	3

The Directors feel that the time has arrived when more members of the Queensland Branch of the British Medical Association should become members of the Company, and would be glad to see a sufficient amount subscribed to take up the unissued shares. Members are asked to induce their friends, who are not shareholders, to subscribe.

(Signed) W. N. ROBERTSON,
Managing Director.

Naval and Military.

APPOINTMENTS.

The following appointments, etc., have been notified in the *Commonwealth of Australia Gazette*, No. 138, of December 18, 1919:—

Australian Imperial Force.

Second Military District.

Captain J. a'B. D. Barton, Australian Army Medical Corps, relinquished the temporary rank of Major and is granted the honorary rank of Major, 5th May, 1919. (This cancels notification regarding this officer which appeared in Executive Minute No. 831, promulgated on page 1794 of *Commonwealth of Australia Gazette*, No. 131/19.)

Lieutenant-Colonel A. L. Buchanan, Australian Army Medical Corps, having resigned, his appointment in the Australian Imperial Force is terminated in England, 27th August, 1919.

Captain R. A. Dart, Australian Army Medical Corps, having resigned, his appointment in the Australian Imperial Force is terminated in England on 20th August, 1919, but to take effect from 4th September, 1919.

Captain A. P. Gunning, Australian Army Medical Corps, having resigned, his appointment in the Australian Imperial Force is terminated in England on 2nd September, 1919, but to take effect from 16th September, 1919.

Major A. J. Macdonald, Australian Army Medical Corps, having resigned, his appointment in the Australian Imperial Force is terminated in England on 1st September, 1919, but to take effect from 24th October, 1919.

Captain L. L. McMahon, Australian Army Medical Corps, having resigned, his appointment in the Australian Imperial Force is terminated in England on 25th July, 1919, but to take effect from 8th September, 1919.

Major J. McPherson, Australian Army Medical Corps, having resigned, his appointment in the Australian Imperial Force is terminated in England on 22nd August, 1919, but to take effect from 6th October, 1919.

Captain G. C. Wellisch, Australian Army Medical Corps, having resigned, his appointment in the Australian Imperial Force is terminated in England on 12th September, 1919, but to take effect from 20th October, 1919.

Major C. J. Wiley, Australian Army Medical Corps, relinquished the temporary rank of Lieutenant-Colonel, and is granted the honorary rank of Lieutenant-Colonel, 7th July, 1919.

Third Military District.

Major R. O. Douglas, Australian Army Medical Corps, to command 1st Australian General Hospital and to be temporary Lieutenant-Colonel whilst so employed, *vice* Colonel R. B. Huxtable, C.M.G., D.S.O., V.D., 18th August, 1919.

Colonel R. Fowler, O.B.E., Australian Army Medical Corps, having resigned, his appointment in the Australian Imperial Force is terminated in England on 8th September, 1919, but to take effect from 7th November, 1919.

Major W. A. Hailes, D.S.O., Australian Army Medical Corps, having resigned, his appointment in the Australian Imperial Force is terminated in England on 5th August, 1919, but to take effect from 27th September, 1919.

Captain V. C. Jennens, Australian Army Medical Corps (Dental), having resigned, his appointment in the

Australian Imperial Force is terminated in England on 8th August. 1919, but to take effect from 22nd September, 1919.

Major L. C. Lade, Australian Army Medical Corps, having resigned, his appointment in the Australian Imperial Force is terminated in England on 25th August, 1919, but to take effect from 9th October, 1919.

Lieutenant-Colonel C. J. Martin, C.M.G., Australian Army Medical Corps, having resigned, his appointment in the Australian Imperial Force is terminated in England on 7th August, 1919, but to take effect from 29th September, 1919.

Captain J. McCusker, Australian Army Medical Corps, having resigned, his appointment in the Australian Imperial Force is terminated in England on 14th August, 1919, but to take effect from 28th September, 1919.

Fourth Military District.

Lieutenant-Colonel (Temporary Colonel) S. R. Burston, D.S.O., Australian Army Medical Corps, ceased to officiate as Assistant Director Medical Services, Headquarters, Australian Imperial Force Depôts in United Kingdom, and relinquished the temporary rank of Colonel and is granted the honorary rank of Colonel, 20th August, 1919.

Captain A. H. Guymer, Australian Army Medical Corps, having resigned, his appointment in the Australian Imperial Force is terminated in England on 27th August, 1919, but to take effect from 11th October, 1919.

Fifth Military District.

Major J. B. Lewis, Australian Army Medical Corps, having resigned, his appointment in the Australian Imperial Force is terminated in England on 2nd September, 1919, but to take effect from 1st November, 1919.

Major M. Yuille, Australian Army Medical Corps, having resigned, his appointment in the Australian Imperial Force is terminated in England on 25th August, 1919, but to take effect from 24th October, 1919.

APPOINTMENTS TERMINATED.

First Military District.

Colonel A. H. Marks, C.B.E., D.S.O., 11th November, 1919.
Major J. J. Power, D.S.O., 9th November, 1919.

Second Military District.

Major E. H. Rutledge, 2nd November, 1919.
Major F. P. M. Solling, M.C., 17th October, 1919.

Third Military District.

Captain F. E. T. True, M.C., 18th October, 1919.

University Intelligence.

THE UNIVERSITY OF SYDNEY.

A meeting of the Senate of the University of Sydney was held on December 22, 1919, at University Chambers, Phillip Street, Sydney.

On the recommendation of the committee appointed by the Senate, Dr. F. Barrington was appointed to the Lectureship in Gynæcology.

On the recommendation of the Faculty of Arts it was resolved that candidates who have failed to complete their matriculation qualifications in November, may do so in March.

The following degrees were conferred *in absentia*: Master of Arts: G. G. Nicholson. Master of Surgery: L. J. Hunter, M.B..

On the recommendation of the Dean of the Faculty of Science, Professor Ewart, Melbourne, and Professor Osborne, Adelaide, were appointed Examiners for the D.Sc. examination.

A letter from the University Scouts in regard to the placing of a gun, the gift of the Department of Defence, on the University grounds, was referred to the Buildings and Grounds Committee.

Dr. H. Priestley was appointed a member of the Australian Institute of Tropical Medicine Committee for its forthcoming sittings.

In regard to the meetings of the Conjoint Board, the following sub-committee was appointed to act with the sub-committee of the Royal Prince Alfred Hospital to consider hospital appointments: The Honourable Mr. Justice Street, Mr. F. Leverrier, Dr. G. H. Abbott and Dr. C. B. Blackburn.

THE UNIVERSITY OF MELBOURNE.

At a meeting of the Council of the Melbourne University, held on December 23, 1919, Dr. J. I. Connor was appointed Stewart Lecturer in Pathology.

At the same meeting it was resolved that the Council approve of the appointment of a Sub-Dean of the Melbourne Hospital Clinical School, to be paid £250 per annum from the clinical fund.

The Council of the Melbourne University is inviting applications for the appointment of a cancer research scholar, tenable for one year. The scholarship is worth £250 per annum. They are also seeking applications for a clinical research scholar, who will be in receipt of an allowance of £50 per annum.

The Otago University has had a windfall. A patriot who prefers to remain anonymous has presented the University with the sum of £2,500.

BOYLSTON MEDICAL PRIZES.

The following notice reached us on December 27, 1919:—

The Boylston Medical Prizes, which are open to public competition are offered for the best dissertation on questions in medical science proposed by the Boylston Medical Committee. At the annual meeting held in Boston in 1916 a prize of three hundred dollars was awarded to an essay entitled "Studies of the Streptococcus of Smith," by Wilson G. Smillie, M.D., of Cambridge, Mass..

For 1919 there is offered a prize of three hundred dollars and the Boylston Prize Medal, for the best dissertation on the results of original research in medicine, the subject to be chosen by the writer. The Boylston Prize Medal will be added to the money prize only in case the winning essay shows special originality in the investigations detailed.

Dissertations entered for this prize must be in the hands of the Secretary, H. C. Ernst, M.D., Harvard Medical School, Boston, Mass., on or before December 31, 1919.

In awarding these prizes, preference will be given to dissertations which exhibit original work, but if no dissertation is considered worthy of a prize, the award may be withheld. Each dissertation must bear, in place of the author's name, some sentence or device, and must be accompanied by a sealed packet, bearing the same sentence or device and containing the author's name and residence within. Any clue by which the authorship of a dissertation is made known to the committee will debar such dissertation from competition. Dissertations must be printed or typewritten and their pages must be bound in book form. All unsuccessful dissertations are deposited with the Secretary, from whom they may be obtained, with the sealed packet unopened, if called for within one year after they have been received.

The Secretary has been directed to publish annually the following votes:—

(1) That the Board does not consider itself as approving the doctrines contained in any of the dissertations to which premiums may be adjudged.

(2) That, in case of publication of a successful dissertation, the author be considered as bound to print the above vote in connexion therewith.

The Boylston Medical Committee is appointed by the President and Fellows of Harvard College and consists of the following physicians: William F. Whitney, M.D. (Chairman), Harold C. Ernst, M.D. (Secretary), William T. Porter, M.D., Edward H. Nichols, M.D., Reid Hunt, M.D., Henry A. Christian, M.D., John Warren, M.D..

The address of the Secretary of the Boylston Medical Committee is Harold C. Ernst, M.D., Harvard Medical School, Boston, Mass..

Obituary.

GERTRUDE ELLA MEAD.

On November 6, 1919, the medical profession suffered a serious loss in the death of Gertrude Ella Mead. It was not known that she was ill until a very short time before her death. On November 3 she complained of feeling weary and remained in bed. Early on the following morning signs of cerebral hæmorrhage were apparent.

Gertrude Ella Mead was born in 1868. She was the daughter of the late Reverend Silas Mead. She was educated at Adelaide and, having determined to take up medicine as career, she matriculated in the Melbourne University and in the year 1897 graduated with the medical and surgical degrees. She then went to England and secured the appointment of house surgeon at the Evelina Hospital for Children. From London she moved to Dublin, where she worked at the Hospital for Women and thence she crossed to Edinburgh and filled a resident position at the Leith Hospital. In 1901 she returned to Australia and in September of that year secured registration in Western Australia. She practised in Perth. At a later date she was appointed Honorary Physician at the Children's Hospital, Perth. She was one of the first members of the Children's Protection Society and one of the founders of the Day Nursery. In addition to her active interest in pædiatrics, Gertrude Mead's name was intimately associated with the district nursing movement in Perth and with numerous other eleemosynary undertakings. She took an active part in the foundation of the University of Western Australia and was elected to the Senate soon after its establishment. In 1910 she visited Europe for a short time after her father's death. She was a lecturer on nursing of the St. John Ambulance Brigade and more recently she gave her services freely to the Voluntary Aid Division of the Red Cross Society. Her life was spent for the advantage of others. In her practice she proved herself especially skilful with children, who were irresistibly drawn toward their kind and capable physician. In her sociological work the aged learned to love her and never looked in vain for sympathetic aid or material assistance. In a quiet, unassuming manner she contributed towards the firm establishment of women's proper place in medicine. Her colleagues, as well as her patients and friends, held her in the highest esteem and deplore a fate that robbed them of her all too soon.

THOMAS THOMPSON DICK.

Thomas Thompson Dick was born at Ayr, Scotland, on January 5, 1840. He studied medicine in Edinburgh and London and graduated in 1861. In 1863, on his arrival in Australia, he practised for a short time at Daylesford. He was then appointed Medical Officer to the Collingwood Stockade, a receiving house for mental patients, and in 1865 he was transferred to the Yarra Bend Asylum, where he served as medical officer. Two years later he was appointed Medical Superintendent at the Beechworth Asylum. He served in this capacity for ten years and in 1877 he became the Medical Superintendent of the Kew Metropolitan Asylum. In March, 1883, he was called upon to fill the position of Inspector of Asylums and to occupy the post of Medical Superintendent at Yarra Bend Asylum. At a later date he gave valuable advice incorporated in his evidence before a Royal Commission appointed to inquire into the Lunacy Service. Unfortunately, his sound advice was not accepted. He held the dual position until June 30, 1894, when he resigned the superintendency of the Yarra Bend institution. An endeavour was made to revive the dual capacity under which he was serving, but he resisted it and preferred to retire rather than to accept responsibilities which one man could not carry.

For many years after his retirement Thomas Thompson Dick enjoyed a country life and country pursuits. He was a very lovable man, in many ways difficult of approach, but was a valuable friend and companion to those who really knew him. He was a man of varied literary tastes and a good French scholar. Many of his friends thought that he should have made more of his knowledge and ability. He would probably have done so, but for his indomitable reserve.

For some years he was afflicted with paralysis agitans. He bore his sufferings like a stoic, recognizing that sooner or later this progressive malady would lay such a hold on him that he would become bed-ridden. This occurred on July 7, 1919. For five months he remained in hospital. His own home in the country was unsuited for the nursing of a helpless patient. After much patient suffering, he died on December 7, 1919, recognizing one of his best friends shortly before the end.

Thomas Thompson Dick is survived by one sister, whom he had not seen since he left Scotland. He was buried at Beechworth, the place he loved. A few old friends remaining were at the graveside, as well as representatives of the Lunacy Department and a few distant relatives and friends from Melbourne.

Correspondence.

THE AUSTRALASIAN MEDICAL CONGRESS.

Sir,—I am sorry to see in the *Journal* of December 20 that it has been determined to continue the congresses under the old system, notwithstanding the resolution of the last congress to hand over its business to the British Medical Association. It is stated that "this resolution has been declared informal," but the identity of the authority which has power to overrule the ruling of the President and decision of the last congress, is withheld.

At each successive congress it became increasingly manifest that these gatherings were impotent to effect any real good for the public or the profession and this belief culminated in the resolution from which so much was hoped and which has now been so wantonly set aside.

Resolutions pregnant with benefits have been passed with sanguine enthusiasm, but have never materialized, because they have been the outcome of an organization with but an intermittent existence, while they needed continuous care. Contrast the achievements of the British Medical Association with those of the congresses; they stand out as a mountain to a mole hill.

It is indisputable that the entirely independent organization of the congresses has hindered the development and progress of the British Medical Association and it was the realization of this fact which decided the last session of congress to take a course by which in future the latter would be the only organization of the medical profession to focus public attention.

No one who has studied the splendid address of Dr. Ramsay Webb, can fail to have been impressed by the urgent need of unity and strength in our profession. Yet this is the time selected to take a retrograde step and resuscitate what has been proved to be a source of weakness.

Under these circumstances I, for one, shall have to deny myself the pleasure of meeting my old friends at Brisbane. I cannot conscientiously contribute even in the humblest way to the success of a gathering which is inimical to the interests of the profession and which I believe is also illegal.

Yours, etc.,

RALPH WORRALL.

Sydney, December 29, 1919.

Proceedings of the Australian Medical Boards

VICTORIA.

The undermentioned have been registered, under the provisions of Part I. of the *Medical Act, 1915*, as duly qualified medical practitioners:—

Niven, Duncan Robertson, M.B. *et* Ch.B., New Zealand, 1917, c/o. Mrs J. S. Thompson, 50 Central Park Road, East Malvern.

Woods, Eric William Beresford, M.B. *et* Ch.B., Melb., 1916, Albury, N.S.W.

Stephenson, Keith Arnold, M.B. *et* Ch.B., Melb., 1918, 51 The Avenue, Windsor.

The name of the late Dr. George Frederic Thomas has been removed from the Register.

Medical Appointments.

The appointment of Dr. C. H. Leedman (B.M.A.) as District Medical Officer from the date of his arrival at Kellerberrin, is announced in the *Government Gazette of Western Australia*.

Dr. P. H. Nutting has been appointed District Medical Officer at Gingin and Dr. G. R. C. Cotton (B.M.A.) at Esperance, Western Australia.

For the purposes of *The Health Acts, 1900 to 1917*, Dr. P. C. Higgins (B.M.A.) has been appointed Health Officer at Port Douglas, Queensland.

Under the provisions of *The Health Acts, 1900 to 1917*, of Queensland, Dr. W. A. Sawyer, Dr. C. P. Rosenthal and Dr. L. Windermere Nott (B.M.A.) have been appointed Health Officers for the purposes of the said Acts.

During the absence of Dr. J. A. Forrest, Dr. W. W. Stevens (B.M.A.) has been appointed Medical Officer at Charters Towers, Queensland.

The appointment is announced of Dr. M. L. Scott (B.M.A.) as Demonstrator in Anatomy at the University of Adelaide, to practise anatomy at the School of Anatomy established in connexion with the University of Adelaide.

Dr. L. A. Hayward (B.M.A.) has been appointed Officer of Health for Berri and District, under the provisions of the *Health Act, 1898*, of South Australia.

Dr. Phoebe Chapple (B.M.A.) and Dr. Harold Rischbieth (B.M.A.) have been appointed Surgeons to the Clinical Department at the Adelaide Hospital.

The appointment of Dr. H. K. Fry (B.M.A.) as Honorary Neurologist to the Adelaide Hospital, is announced.

Medical Appointments Vacant, etc.

For announcements of medical appointments vacant, assistants, locum tenentes sought, etc., see "Advertiser," page xxi.

Victorian Eye and Ear Hospital: Resident Surgeon.

Hospital for Sick Children, Brisbane: Two Honorary Physicians to Out-Patients, one Honorary Surgeon to Out-Patients, one Honorary Assistant Surgeon for the Ear, Nose and Throat Department.

Medical Appointments.

IMPORTANT NOTICE.

Medical practitioners are requested not to apply for any appointment referred to in the following table, without having first communicated with the Honorary Secretary of the Branch named in the first column, or with the Medical Secretary of the British Medical Association, 429 Strand, London, W.C.

Branch.	APPOINTMENTS.
VICTORIA. (Hon. Sec., Medical Society Hall, East Melbourne.)	All Friendly Society Lodges, Institutes, Medical Dispensaries and other Contract Practice. Australian Prudential Association Proprietary, Limited. Mutual National Provident Club. National Provident Association.
QUEENSLAND. (Hon. Sec., B.M.A. Building, Adelaide Street, Brisbane.)	Australian Natives' Association. Brisbane United Friendly Society Institute. Cloncurry Hospital.
SOUTH AUSTRALIA. (Hon. Sec., 3 North Terrace, Adelaide.)	Contract Practice Appointments at Renmark. Contract Practice Appointments in South Australia.
WESTERN AUSTRALIA. (Hon. Sec., 6 Bank of New South Wales Chambers, St. George's Terrace, Perth.)	All Contract Practice Appointments in Western Australia.
NEW SOUTH WALES. (Hon. Sec., 30-34 Elizabeth Street, Sydney.)	Australian Natives' Association. Balmain United Friendly Societies' Dispensary. Canterbury United Friendly Societies' Dispensary. Friendly Society Lodges at Casino. Friendly Society Lodges at Lithgow. Friendly Society Lodges at Parramatta, Auburn and Lidcombe. Leichhardt and Petersham Dispensary. Manchester Unity Oddfellows' Medical Institute, Elizabeth Street, Sydney. Marrickville United Friendly Societies' Dispensary. Newcastle Collieries—Killingworth, Seaham Nos. 1 and 2, West Wallsend. North Sydney United Friendly Societies. People's Prudential Benefit Society. Phœnix Mutual Provident Society.
NEW ZEALAND: WELLINGTON DIVISION. (Hon. Sec., Wellington.)	Friendly Society Lodges, Wellington, New Zealand.

Diary for the Month.

Jan. 6.—N.S.W. Branch, B.M.A., Council (Quarterly).
Jan. 6.—Tas. Branch, B.M.A., Branch and Council.
Jan. 9.—Q. Branch, B.M.A., Council.
Jan. 9.—S. Aust. Branch, B.M.A., Council.
Jan. 13.—N.S.W. Branch, B.M.A., Executive and Finance Committee; Ethics Committee.
Jan. 15.—Vic. Branch, B.M.A., Council.
Jan. 17.—Northern Suburbs Med. Assoc. (N.S.W.).
Jan. 20.—Tas. Branch, B.M.A., Branch and Council.
Jan. 20.—N.S.W. Branch, B.M.A., Medical Politics Committee; Organization and Science Committee.
Jan. 23.—Q. Branch, B.M.A., Council.
Jan. 28.—Tas. Branch, B.M.A., Annual Meeting.
Jan. 28.—Vic. Branch, B.M.A., Council.
Jan. 29.—S. Aust, Branch, B.M.A..
Jan. 29.—Central Western Med. Assoc. (N.S.W.), 8.30 p.m., at the Woolpack Hotel, Parramatta.

EDITORIAL NOTICES.

Manuscripts forwarded to the office of this journal cannot under any circumstances be returned.

Original articles forwarded for publication are understood to be offered to *The Medical Journal of Australia* alone, unless the contrary be stated.

All communications should be addressed to "The Editor," *The Medical Journal of Australia*, B.M.A. Building, 30-34 Elizabeth Street, Sydney. (Telephone: City 2045.)